

**Understanding Trans Racialized Youth Autonomy
in Health Care Decision Making in Ontario**

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Abstract

This thesis re-evaluates the concept of autonomy and the possibilities for trans racialized youth to practice it in current health care decision making contexts. After discussing access to health care in Ontario for this demographic using diverse research, an analytical foundation is laid using legal pluralism, relational autonomy, transgender theory and disidentification theory.

The study uses Photovoice with trans racialized youth to produce visual texts analysed using thematic network analysis. Secondly, the study considers how together, law and medicine discursively work to encourage law-makers and health care providers to undermine the autonomy of trans racialized youth. Authoritative diagnostic and clinical texts are examined alongside decisions from courts and tribunals where trans racialized youth are present.

Despite the autonomy granted in Ontario's *Health Care Consent Act*, structural vulnerability, judicial paternalism, failure to mandate youth awareness of health care rights and professional ignorance restrict the autonomy practice of trans racialized youth.

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Chapter 1: Searching for Trans Racialized Youth

Introduction

A timeline of the events that propelled me to research the autonomy experiences of trans racialized youth in health care will give you, the reader, some perspective.¹ In 2014, North Americans were stunned when Leela Alcorn, a 16-year-old trans teen, walked in front of a truck on the Ohio Interstate, because she could not bear her parents' refusal to consent to her transition. Her suicide note, posted to her Tumblr page, described the bleakness of her future as a "man in drag".² Only one year before her suicide, the American Psychiatric Association officially renamed Alcorn's diagnosis of "gender identity disorder of childhood" as the less pathologizing "Gender Dysphoria" in the latest version of its *Diagnostic and Statistical Manual of Mental Disorders (DSM-V)*.³ In the same year as Alcorn's death, Ontario added gender identity and gender expression to its Human Rights Code as a prohibited ground of discrimination in response to years of litigation and activism by trans communities.⁴ Then in

¹ Since race is constructed socially, I use race as a process, the Report of the Commission on Systemic Racism in the Ontario Criminal Justice System defined racialization "as the process by which societies construct races as real, different and unequal in ways that matter to economic, political and social life." *Ontario Human Rights Commission & Ontario Human Rights Commission, Policy and guidelines on racism and racial discrimination*. (Toronto: Ontario Human Rights Commission, 2005) at 11.

² Alcorn's original Tumblr was deleted at her parents' request but was retrieved and posted on Leela Alcorn, "Leelah Alcorn's Blog (Lost 2014 Tumblr Webpage)", (30 December 2014), online: Lost Media Arch <[http://lostmediaarchive.wikia.com/wiki/Leelah_Alcorn%27s_Blog_\(Lost_2014_Tumblr_Webpage\)](http://lostmediaarchive.wikia.com/wiki/Leelah_Alcorn%27s_Blog_(Lost_2014_Tumblr_Webpage))>.

³ American Psychiatric Association & American Psychiatric Association: *DSM-5 Task Force, Diagnostic and statistical manual of mental disorders: DSM-V, 5th ed.* (Arlington, VA: American Psychiatric Association, 2013); *American Psychiatric Association, DSM V Update Supplement to Diagnostic and Statistical Manual Of Mental Disorders*, Fifth Edition (American Psychiatric Association Publishing, 2016) at 19.

⁴ *An Act to amend the Human Rights Code with respect to gender identity and gender expression*, 20120619, 2012 2012 C 7 [Toby's Act (*Right to be Free from Discrimination and Harassment Because of Gender Identity or Gender Expression*)]; *Ontario Human Rights Code*, RSO 1990 [Ontario Human Rights Code].

2015, Ontario passed a statute banning the use of conversion therapy by mental health professionals on LGBTTTQ and questioning minors in Ontario.⁵ Later that year, Toronto's Centre for Addictions and Mental Health (CAMH) closed the youth wing of its Gender Identity Clinic (GIC) to new patients after an independent review was conducted amidst a trans community outcry over conversion therapeutic practices deployed against gender questioning youth.⁶ The Clinic had built its international research reputation through treating over 650 patients.⁷ Then in 2016, the amended Regulation 552 of the *Health Insurance Act* improved OHIP delivery to allow more classes of healthcare practitioners to recommend trans people for gender affirming surgeries thus reducing the years long wait lists at the CAMH GIC.⁸ Taken collectively, these were considerable legal and social policy reforms that would ostensibly improve conditions for Ontario trans youth in the same situation as Leela Alcorn.

Indeed, mainstream LGBTTTQ activists and allies celebrated provincial and federal human rights recognition for gender identity and gender expression and the availability of punitive sanctions for hate crimes.⁹ Yet, critical trans scholars and activists called these reforms symbolic

⁵ *An Act to amend the Health Insurance Act and the Regulated Health Professions Act*, 1991 regarding efforts to change sexual orientation or gender identity SO 2015 C.18.

⁶ While CAMH's External Review was removed from their website, Emily Colero, "CAMH removes external review of Gender Identity Clinic from website", *The Varsity* (8 February 2016), online: <<https://thevarsity.ca/2016/02/08/camh-removes-external-review-of-gender-identity-clinic-from-website/>>; the archived copy of the External Review was accessed through Cristan Williams, "The Rise and Fall of Disco Sexology Part 1", (2016), online: *Rise Fall Disco Sexol* <transdvocate.com/part-i-the-rise-and-fall-of-disco-sexology-dr-zucker-camh-conversion-therapy_n_19556.html> [Williams].

⁷ Erin Anderssen, "Gender identity debate swirls over CAMH psychologist, transgender program", *Globe Mail* (14 February 2016), online: <<http://www.theglobeandmail.com/news/toronto/gender-identity-debate-swirls-over-camh-psychologist-transgender-program/article28758828/>>.

⁸ *Health Insurance Act*, 1990, RSO 1990 C H6 [Health Insurance Act], RRO 1990, 552.

⁹ *An Act to amend the Canadian Human Rights Act and the Criminal Code*, 19 2017, 2017 C 13 [An Act to amend the Canadian Human Rights Act and the Criminal Code]; John Ibbitson, "With gender identity bill, Canada shows leadership in advancing human rights", online: <<https://www.theglobeandmail.com/news/politics/with-gender-identity-bill-canada-shows-leadership-in-advancing-humanrights/article35323583/>>; Phil Heidenreich, "Senate passes Bill C-16 which defends transgender rights", (16 June 2017), online: *Global News* <<https://globalnews.ca/news/3532824/senate-passes-bill-c-16-which-defends-transgender-rights/>>; "Bill C-16 more

and even detrimental to marginalized segments of trans communities.¹⁰ Similarly, since the mid-90s enactment of its health consent statute, Ontario celebrated the autonomy of the individual to make decisions about their health, yet it seemed, from anecdotal evidence, that trans racialized youth do not actually enjoy this autonomy.¹¹ This is because they are not accessing gender-affirming treatments at the same rate as their white youth counterparts. My broad research project is firstly to verify and understand the reasons behind this inequitable phenomenon by examining the law and policy undergirding the medico-legal regulation of care to trans racialized youth and secondly, to undertake to learn from their experiences about health care decision making firsthand in their own words and photographs.

I began by mapping the terrain of existing academic literature about trans racialized youth. Two challenges characterized this initial review: Firstly, the group at the heart of this research embodies specificities of race, gender identity, ability and age simultaneously. Their lives are constituted throughout these intersections and yet the literature concerning trans youth is anything but intersectional. Research mostly pertains to white youth but is presented as universal. Secondly, my research question compelled me to straddle several disciplines that produce different and contesting knowledges about trans people and youth. Thus, with intersectionality and interdisciplinarity in mind, I searched for overlaps through health and social science research, legal theory, trans studies and medical history for information about trans

reason to celebrate for Toronto trans marchers”, (23 June 2017), online: CBC <<https://www.cbc.ca/news/canada/toronto/toronto-trans-march-pride-bill-c-16-1.4176011>>.

¹⁰ Viviane Namaste, *Sex Change, Social Change: Reflections on Identity, Institutions, and Imperialism* (Canadian Scholars' Press, 2011); Dean Spade, “What’s Wrong with Trans Rights” in Anne Enke, ed, *Transfeminist Perspect Transgender Gend Stud* (Philadelphia: Temple University Press, 2012).

¹¹ *Health Care Consent Act, 1996, SO 1996, c. 2, Sched. A*, Government of Ontario, 24 July 2014 [*Health Care Consent Act*].

racialized youth's material conditions, health needs and autonomy practices.¹² Furthermore, from the outset of this project I affirmed the importance of using as much literature as possible by trans racialized scholars and where that was not available, white trans scholars. Deliberately then, my review begins with the work of a group of critical trans scholars who research how sexual and gender difference is absorbed and mobilized by discourse producing institutions such as medicine and law into Foucauldian "technologies of control".¹³ Trans of colour critique seeks to articulate the voices and interests of Black, Indigenous queer and trans communities of colour (BIPOC). My project is necessitated by the ongoing dismissal of trans BIPOC lives from within mainstream trans activisms, clinical research, and trans archives.¹⁴

My work is unique as it speaks across often disparate fields and does so in a coherent way that shares new data and advances the thinking in each individual field. Specifically, my work intersects Children and Youth Studies, Queer and Trans Studies, Critical Race Theory, Legal Philosophy, and Health Equity Law, within overarching paradigms of Legal Pluralism and qualitative research using arts-based/Photovoice methodology.

Defining "Youth"

There are many different terms that are used to discuss the age-ranges of the participants in this research. Categories such as "children", "adolescent", "youth", and "young adult" are

¹² Kristin Luker, *Salsa Dancing into the Social Sciences* (Harvard University Press, 2009) at 81–83 describes the bedraggled daisy method for conducting interdisciplinary literature reviews.

¹³ Jin Haritaworn, Adi Kuntsman & Silvia Posocco, eds, *Queer Necropolitics* (Abingdon, Oxon: Routledge, 2014) at 3.

¹⁴ C Riley Snorton & Jin Haritaworn, "Trans Necropolitics: A Transnational Reflection on Violence, Death and the Trans of Color Afterlife" in Susan Stryker & Aren Z Aizura, eds, *Transgender Studies Reader* (New York: Routledge, 2013) 66 at 67-69.

commonly used in law, medicine and social services to refer to, treat and govern young people.¹⁵ The way institutions and academic fields discursively deploy age categories and developmental life stages reveals a lot about each institution's prevailing values and practical goals. As I will explain, these terms are not mutually exclusive nor are they standardized in provincial, national, and international contexts.

Statutory law uses categories to make an age-based distinction between people. For example, the term "minor" distinguishes younger people from those who have reached the age of the "majority" which was once synonymous with attaining adulthood. In Ontario the *Age Of Majority And Accountability Act* states the age of majority as 18.¹⁶ Interestingly, while 18 year olds are allowed to vote they may not purchase cigarettes, alcohol or marijuana until they are 19.¹⁷ In the federal realm of criminal law the *Youth Criminal Justice Act* defines a "young person" and a "youth" as between the ages of 12 and 17.¹⁸ Age of majority and health care consent legislation in Canada varies across each province. The words "infant" and "child" and "minor" are used interchangeably to refer to people under the age of majority for each province. For example, in British Columbia, anyone under the age of 19 is a minor and the *Infancy Act* regulates their health care consent.¹⁹

At the international level the United Nations has defined the term "youth" since 1985 as people aged 15-24 years in its research, documentation and advocacy.²⁰ However this does not

¹⁵ Soo Ah Kwon, *Uncivil youth: race, activism, and affirmative governmentality* (Durham; London: Duke University Press, 2013) at 27–29.

¹⁶ Age of Majority and Accountability Act, RSO 1990, c. A.7, s.1.

¹⁷ *Canada Elections Act* SC 2000, c. 9 s.3; *Liquor Licence Act*, RSO 1990, c. L.19 s. 30; *Smoke-Free Ontario Act*, 2017, SO 2017, c. 26, Sched. 3 s. 3(1); *Cannabis Control Act*, 2017, SO 2017, c. 26, Sched. 1 ss. 7 and 10.

¹⁸ *Youth Criminal Justice Act* (SC 2002, c. 1 s 2(1)).

¹⁹ *Age of Majority Act* [RSBC 1996] Chapter 7 Ss. 1 And 4; *Infants Act* [RSBC 1996] Chapter 223 S.17.

²⁰ United Nations Educational, Scientific and Cultural Organization, "Youth - Definition", (2017), online: What We Mean Youth <<http://www.unesco.org/new/en/social-and-human-sciences/themes/youth/youth-definition/>>.

align with the *Convention on the Rights of the Child* (CRC) where the category of “children” extends up to, but not including, 18 years of age.²¹ This range is much wider than domestic definitions of children, that stop at age 12, and is most likely deployed as a strategy to protect as many young people as possible under the CRC’s provisions.

At the turn of the 20th century, psychology as a field led the move to establish adolescence as a category denoting a physical and emotional stage of human development.²² By white/Western externally measured standards, emerging out of adolescence involves exhibiting: physical changes, developmental changes associated with values of independence, material independence, established peer social groups, and romantic relationships of permanence.²³ Similarly, in the practice of pediatric medicine, the term “minor” is not used and paediatricians instead use the medical term “adolescents” who are defined by their physiological stage as 12-18 year olds.²⁴ In medicine, “children” are people under the age of 12.²⁵ The clinical term “adolescent” and the legal term “minor” carry outdated culturally-loaded connotations yet they remain prevalent in the medical and legal sources I examined for this thesis.²⁶ The way both terms are used have limited capacity to capture the experiences of trans racialized youth, such as transphobia, and racism that

²¹ Convention on the Rights of the Child General Assembly resolution 44/25 of 20 November 1989, Article 1.

²² G Stanley Hall, *Adolescence: its psychology and its relations to physiology, anthropology, sociology, sex, crime, religion and education* (New York: Appleton, 1907).

²³ *Ibid.*

²⁴ D, Sacks, “Age limits and adolescents | Canadian Paediatric Society”, (reaffirmed 2016 2003), online: Can Paediatr Soc <<https://www.cps.ca/en/documents/position/age-limits-and-adolescents>>.

²⁵ *Ibid.*

²⁶ Marlis Buchmann, *The Script of Life in Modern Society: Entry Into Adulthood in a Changing World* (University of Chicago Press, 1989); James E Côté & Anton Allahaar, *Generation on hold: coming of age in the late twentieth century* (Toronto, Ont: Stoddart, 1994); Johanna Wyn & R D White, *Rethinking youth* (London: Sage Publications, 1997). Legal clinics serving people under 18 use the term youth not the value-laden term “minor” such as Justice 4 Children and Youth.

are not bound by age or physiological parameters.²⁷ Minor youth may encounter specific barriers related to parental consent to minor's health care that overlap with the adolescent need for puberty-related care. Yet as this chapter demonstrates, parental controls and financial and social barriers to independent housing and secure employment extend to trans racialized and particularly Indigenous youth in early adulthood even more than their white or cis counterparts of the same generation.²⁸

In contrast, the term “youth” connotes a transitional social concept of age that encompasses both children and young adults, minors and people who have reached the age of majority.²⁹ Yet, in the Canadian operational administrative context, usage of the category of “youth” has proliferated, and the category itself has broadened. For example, Employment and Social Development Canada (EDSC) did not define youth but canvassed thousands of young Canadians under 16 and over 30 years old for their 2018 Youth Policy. Older Statistics Canada surveys classified youth as 16-28 years old, and young adults as 20-24 years old,³⁰ however in its 2018 “Portrait of Canadian Youth” Statistics Canada considers youth to range from 15-34.³¹ These expansions to the categorization of youth perhaps reflects the economic and social challenges faced by a larger number of young adults in securing jobs, homes, and relationships that once

²⁷ Carrie Davis, “Introduction to Practice” in Gerald P Mallon, ed, *Soc Work Pract Transgender Gend Var Youth*, 2nd ed (London: Routledge, 2009) 1 at 11.

²⁸ Carrie Davis, *supra* note 27; see *infra* note Nicole Nussbaum, et al, *Legal Problems Facing Trans People in Ontario, TransForming Justice: Legal Needs Assessment of Trans People in Ontario Summary Report 1* (Toronto, ON: Legal Aid Ontario, HALCO, Ryerson University, University of Western Ontario, University of Toronto, 2018) in Youth Data Set.

²⁹ United Nations Educational, Scientific and Cultural Organization, *supra* note 20; Buchmann, *supra* note 26 at 82–83.

³⁰ Statistics Canada, “Children and youth”, (November 2012), online: Can Yearb <<https://www150.statcan.gc.ca/n1/pub/11-402-x/2011000/chap/c-e/c-e-eng.htm>>.

³¹ Statistics Canada Government of Canada, “A Portrait of Canadian Youth”, (7 February 2018), online: <<https://www150.statcan.gc.ca/n1/pub/11-631-x/11-631-x2018001-eng.htm>>.

signified adulthood.³² In the Ontario social services context, providers use similar broad age ranges in some cases with an upper limit of 29.³³ This range allows health and social services providers to serve more trans people whose gender-affirming health needs do not end after the urgency of the initial pubertal stage has finished.³⁴ In particular, trans racialized youth often access services later than white trans youth, due to these aforementioned socially determined barriers that will be discussed in detail below.³⁵

For my research I decided to employ the broad definition of youth because I wanted to focus on how trans racialized people were accessing health related services offered in private and public clinical sites regardless of being minors or not. I was trying to work less categorically and more relationally and intersectionally as I explain in Chapter 2.³⁶ In these sites the term “youth” was used to refer to youth and adolescents over 18, perhaps because it is a term commonly used by young people themselves.³⁷

The presumption that Ontario minors have independent health care decision-making authority was one I wanted to trouble with respect to trans racialized youth. Secondly, I wanted to investigate whether trans racialized youth 18 and over were subjected to paternalistic and infantilizing attitudes by health care providers and legal practitioners despite not legally being minors.

³² James E Côté, *Arrested adulthood: the changing nature of maturity and identity* (New York: New York University Press, 2000) at 3–5, 29.

³³ Supporting Our Youth at the Sherbourne Health Centre <http://soytoronto.org>, and Planned Parenthood Toronto, <http://www.ppt.on.ca/>. Central Toronto Youth Services programs apply age cut-offs based on the age ranges applied by the Ministry which funds the program.

³⁴ Websites for Justice for Children and Youth who work only with minors

³⁵ Jake Pyne, *The Temporality of Privilege: Trans Youth of Colour and the Trouble with Triage* (PhD Dissertation, McMaster University, 2018) [unpublished].

³⁶ Wyn & White, *supra* note 26 at 96.

³⁷ The Sick Kids Transgender Youth Clinic website uses the terms “youth” and “adolescent” interchangeably, see <http://www.sickkids.ca/AdolescentMedicine/transgender-youth-clinic.html>

Critical Trans Studies and Trans of Colour Critique

Several ruptures exist between the swiftly growing field of critical trans studies and the mainstream trans and LGBTQ movements. Some argue that mainstream successes in legal recognition of gender identity and social inclusion have not changed material circumstances for many communities.³⁸ It is within this wave of resistances to material crises that I place my research on decision-making autonomy for trans racialized youth. I will first define and describe the foundational concept of “transnormativity”. I will then review the grouping of works that use ‘trans’ necropolitics as a theoretical container for trans of colour critique. Transnormativity is a phenomenon through which the people who can most successfully be absorbed into existing social power relations are recognized in law, dominate media discourses, and direct advocacy choices while universalizing their experiences on to those who are deemed insoluble.³⁹

The slow regulated death of the insoluble others is at the heart of Mbembe’s concept of necropower.⁴⁰ His was both a critique of and an extension of Foucault’s concept of biopower and his theory of racism. Racism is a technology of biopower that categorizes populations into scientifically determined subdivisions across which life and death outcomes are unevenly allocated. This is an alternative way of understanding power in late modern societies.⁴¹ I will

³⁸ Florence Ashley, “Don’t be so Hateful: The Insufficiency of Anti-Discrimination and Hate Crime Laws in Improving Trans Well-Being” (2018) 68:1 Univ Tor Law J 1; Ido Katri, “Transgender Intrasectonality: Rethinking Anti-Discrimination Law and Litigation” (2017) 20 Univ Pa J Law Soc Change [i].

³⁹ Dan Irving, “Normalized Transgressions: Legitimizing the transsexual body as productive” (2008) 100: Special Radic Hist Rev 38; Jena McGill & Kyle Kirkup, “Locating the Trans Legal Subject in Canadian Law: XY v Ontario” (2013) 33 Windsor Rev Leg Soc Issues 96; Snorton & Haritaworn, *supra* note 14.

⁴⁰ Achilles Mbembe, “Necropolitics” (2003) 15:1 Public Cult 11.

⁴¹ “Becoming subject therefore supposes upholding the work of death” at 14. Foucault *Il Faut défendre la société* at 228; Mbembe identifies the Atlantic slave trade and slavery as one of the first examples of biopolitical experimentation and he calls plantations and colonies repressed topographies of cruelty Achilles Mbembe, “Necropolitics” (2003) 15:1 Public Cult 11 at 21, 40.

describe below how population level controls were supported by eugenics studies in Europe and the United States based on “scientific” ontologies of race and sex.⁴²

In *Queer Necropolitics* Haritaworn et al. inquire into what conditions make trans normative political strategies, such as the expansion of hate crimes legislation, desirable.⁴³ The editors also follow the implications of inclusion-seeking strategies for trans people of colour.⁴⁴ *Queer Necropolitics* takes up Mbembe’s claim that new technologies of necropower continue to be adapted and utilized.⁴⁵ They push the practice of trans studies to “focus less on the grand moments or processes of commemoration and more on the everyday and the ordinary.”⁴⁶ Their critical turn to the daily material realities of trans racialized youth guided my research.

Trans activists and academics remind cis feminists of the historical and current material differences between them as women.⁴⁷ They look beyond interpersonal experiences of transphobia and racism to the institutional contexts in which those differences arise, for example through the intersections of criminalization of trans status, citizenship status, sex workers’ rights

⁴² M. Foucault, *Il Faut défendre la société*, 58-70.

⁴³ Haritaworn et al *supra* note 13; See Jasbir Puar’s earlier use of term “queer necropolitics” in Jasbir K Puar, *Terrorist Assemblages: Homonationalism in Queer Times*, unknown edition ed (Durham: Duke Univ Pr, 2007) at 36.

⁴⁴ Dean Spade, Morgan Bassichis & Alexander Lee, “Building an Abolitionist Trans and Queer Movement with Everything We’ve Got” in Eric Stanley & Nat Smith, eds, *Captive Genders Trans Embodiment Prison Ind Complex*, 2nd ed (Oakland California: AK Press, 2015) 21 is an example of such a multi-issue exploration.

⁴⁵ Snorton and Haritaworn *supra* note 39 at 71 concluding that the deaths of trans women of colour provide raw materials for trans social movements that advance the lives of privileged white gay, queer and trans people. Lastly, there is a thematic linkage between Mbembe, the project of *Queer Necropolitics*, and an earlier essay by Snorton and Haritaworn titled “Trans Necropolitics” 45.

⁴⁶ Haritaworn et al 2014 *supra* note 43 at 2.

⁴⁷ Trans scholars in feminist studies and sociology have repeatedly asked for research and writing on transness to actually attempt to improve or at least note the material conditions of the lives of marginalized trans people rather than theorize post-structuralism and queer theory, see Viviane Namaste, “Undoing Theory: The ‘Transgender Question’ and the Epistemic Violence of Anglo-American Feminist Theory” (2009) 24:3 *Hypatia* 11; for a comparison of the work of Namaste and Judith Butler see also Trish Salah, “Undoing Trans Studies” (2007) 0:17 *TOPIA: Canadian Journal of Cultural Studies* 150; and see Jake Pyne, “Queer and Trans Collisions in the Classroom: A Call to Throw Open Theoretical Doors in Social Work Education” in (2016) 54.

as workers, and the disabling of certain members of society.⁴⁸ My research heeds this reminder by placing trans racialized youth who do not *actually* benefit from recent transnormative policy interventions and legislative reforms in the foreground of the picture.

The “Newness” of Trans Youth of Colour

What does race have to do with being trans?⁴⁹ The obvious answer is that trans racialized people exist, and as I explain in Chapter 2, they lead intersectional lives.⁵⁰ The longer answer is that trans racialized people only seem new to discourses that have so far erased them such as histories of science, LGBT cultural histories, and media coverage of trans lives. I can begin to answer that same question discursively if I look backwards for a medical history of transsexuality that integrates “scientific” theories of race. The field of sexology emerged out of endocrinology, eugenics, and the “psych” fields of study. Several scholars trace the development of the field from the late nineteenth century through to early twentieth medical history of transsexuality. They begin with European sexology and psychoanalysis and continue through American sexology, endocrinology and psychiatry. These medical histories are useful because they demonstrate how medical science laid the groundwork for the legal tendency I explicate in

48 Trish Salah, “Gender Struggles: Reflections on Trans Liberation, Trade Unionism, and the Limits of Solidarity” in Dan Irving & Rupert Raj, eds, *Trans Activism in Canada: A Reader* (Toronto: Canadian Scholars’ Press, 2014); and Nora Butler Burke, “Connecting the Dots: National Security, Crime Migration Nexus and Trans Women’s Survival” in Yolanda Martínez-San Miguel & Sarah Tobias, eds, *Trans studies: the challenge to hetero/homo normativities* (New Brunswick, New Jersey: Rutgers University Press, 2016) and also Nora Butler Burke, “Double Punishment: Immigration Penalty and Migrant Trans Women Who Sell Sex” in Emillie Durisin, ed, *Sex/Work Regulation Agency and Resistance* (British Columbia: UBC Press, 2018).

49 Nael Bhanji, “Trans/scriptions: Homing Desires, (Trans)sexual Citizenship and Racialized Bodies.” in Stryker & Aizura, *supra* note 14, 512 at 519.

50 Nova Gutierrez, “Resisting Fragmentation, Living Whole” (2004) 16:3–4 *J Gay Lesbian Soc Serv* 69; Anneliese Singh, “Transgender Youth of Colour and Resilience: Negotiating Oppression and Finding Support” (2013) 68 *Sex Roles* 690 [Singh 2013a]; Anneliese Singh, Sarah E Meng & Anthony W Hansen, “‘I am my Own Gender’: Resilience Strategies of Trans Youth” (2014) 92 *J Couns Dev* 208 [Singh et al 2014].

Chapter 4, which is to normalize transsexualism by absorbing it into the established gender binary.⁵¹ All scholars however, failed to acknowledge the connection between scientific typologies of race and the creation of the category of transsexuality. Their related theories on law and political economy branch out from incomplete histories of transsexuality.⁵² It is partly these selective research gaps that facilitate the framing of trans racialized youth as new entities despite their centuries-old existence.⁵³ A parallel erasure in the official cultural history of transness has been met by Black scholars and cultural workers who demonstrate that BIPOCs are not recent add-ons to this current trans youth moment. In fact, Black and Latinx trans youth like Marsha P. Johnson and Sylvia Rivera led 20th century LGBTTTQ activism in the cities of New York and Compton.⁵⁴ This activism was necessitated by their structural vulnerability to the regulation of race, gender, citizenship status, and by being targeted by law enforcement.⁵⁵ And thirdly, trans racialized youth have called attention to the media's neglect of their lives as they responded to the media eruption over Alcorn's death. They write this: "No offense to Leelah Alcorn, may her soul rest in peace, but where is the press coverage of the eight to 10 African-American transgender girls that have been murdered this year?"⁵⁶

⁵¹ Andrew N Sharpe, *Transgender jurisprudence: dysphoric bodies of law* (London: Cavendish, 2002) at 519.

⁵² Dean Spade, "Resisting medicine, re/modeling gender" (2003) 18 Berkeley Womens LJ 15; Irving 2008 *supra* note 39; Sharpe 2002 *ibid*.

⁵³ Singh 2013a, *supra* note 50; Syrus Marcus Ware, "All Power to All People?" (2017) 4:2 Transgender Stud Q 170 at 171 and 172; Edward Ou Jin Lee, "Trans Youth of Color: Knowledges, Realities and Practice Strategies" in Elizabeth J Meyer & Annie Pullen-Sansfaçon, eds, *Support Transgender Gend-Creat Youth Sch Fam Communities Action, Gender and sexualities in education*; v 9, revised edition. ed (New York: Peter Lang, 2018) 87; Pyne 2018, *supra* note 35 at 105.

⁵⁴ Che Gossett, "Silhouettes of Defiance: Memorializing Historical Sites of Queer and Transgender Resistance in an Age of Neoliberal Inclusivity" in Stryker & Aizura, *supra* note 14, 580 at 582, 584–5; Ware, *ibid* at 172.

⁵⁵ Ware, *supra* note 53 at 172 Ware writes that "Our relationship to the law changes our relationships to space and organizing and creates a certain set of freedoms and also restrictions in our work."

⁵⁶ Nicole Pasulka, "After Leelah Alcorn's Suicide, Trans Youth Fight Broader Bias", (8 January 2015), online: Code Switch Race Identity Remixed <<https://www.npr.org/sections/codeswitch/2015/01/08/375203856/trans-teens-respond-to-leelah-alcorns-death>>.

Returning to the role of race in the creation of transness, notably, the work of Julien Gill-Peterson uncovers the convergence of racial categories and sexological inquiries challenging previous academic omissions. Most relevant to this project is Gill-Peterson's genealogy of trans children and youth. He also shows that racialized children have always been a focus for sexological and medical research in the United States for eugenic reasons.⁵⁷ Scientific racism most obviously manifested itself in the study of eugenics throughout Europe and America.⁵⁸ Eugenics was the pursuit of racial improvement premised on white supremacy and ableism by normalizing deviant racial and sexual subgroups. And as Gill-Peterson concludes in his genealogy of trans children:

The child's body, then, is intrinsic to the genealogy of sex and race as bound by endocrinology, even if the children being treated by endocrinologists did not begin to be labeled as transsexual, like G.L., until the 1960s. The neglect of the developmental function of childhood and the child's body to some extent explain the facile forgetting of the genealogy of the transgender child...It also accounts for the apparent exogenous quality of race to transgender studies and the transgender child, where, if broached at all, race is merely a matter of minority identity and its intersection with sex and gender.⁵⁹

He concludes that while in the 21st century trans and gender independent kids are reported on as though they are a new phenomenon, the control of adolescence as a key developmental stage in the life of the species was significant as early as the 1960s.⁶⁰ Gill-Peterson's earlier work also focused on trans youth, puberty suppression through the use of hormone blockers and the

⁵⁷ Julian Gill-Peterson, *Queer Theory is Kids Stuff: A Genealogy of the Gay and Transgender Child* (Rutgers, 2015) [unpublished] at 11, 24.

⁵⁸ Gill-Peterson *ibid*, see also Siobhan B Somerville, *Queering the Color Line* (Durham, N.C: Duke University Press, 2000), in which she argues that race and sexuality were intertwined in the medical and legal histories of homosexuality.

⁵⁹ Gill-Peterson *ibid* at 154.

⁶⁰ Gill-Peterson *ibid* at 11, 24.

discovery of the transsexual body's plasticity from the study of hormones by endocrinologists steeped in scientific racism.⁶¹ He frames puberty suppression as an example of modern trans biopolitics developed from endocrinology's interest in disrupting the body's inherited racial and sexual characteristics.⁶² Nineteenth and 20th century endocrinologists were interested in what they termed "precocious puberty" associated with "tropical populations" i.e. racialized people of the Global South.⁶³ Rather than being an add-on to gender identity, race *is* a technical capability of the body that can be manipulated to make it plastic and therefore to make it trans. Gill-Peterson remarked on the irony of the high cost of Lupron, a puberty blocking drug, reasoning that cost functioned as a prohibitive barrier to trans and gender non-conforming pubertal age racialized youth who are less likely to have Medicaid or Medicare or private health insurance.⁶⁴ This is confirmed by U.S. research scrutinizing Medicare service claims data over 10 years.⁶⁵ The study found that when a puberty-blocking implant called Vantas was prescribed for the diagnosis of gender dysphoria the claimants were 74 per cent "white non-Hispanic" but when the same drug was prescribed for "precocious puberty", which is the labelled purpose of the drug, the number of racialized recipients matched the number of white ones.⁶⁶ This ratio indicates a disproportionately high number of racialized youth billing for a drug to delay precocious puberty, rather than to address gender dysphoria.

⁶¹ Julian Gill-Peterson. "The Technical Capacities of the Body: Assembling Race, Technology, and Transgender" (2014) 1:3 TSQ 402 [Gill-Peterson 2014].

⁶² *Ibid* at 408.

⁶³ *Ibid* at 413. The role of tropical colonial studies in the development of psychiatry is explored later in Chapter 4.

⁶⁴ *Ibid* at 414.

⁶⁵ CMD Lopez et al, "Trends in the use of Puberty Blockers among Transgender Children in the United States" (2017) 2:2 J Pediatr Encrinology 1.

⁶⁶ *Ibid* at 4.

In Toronto, anecdotal evidence of low to zero numbers of trans racialized youth using trans youth services and gender clinics prompted me to interview between 2016 and 2017 three doctors who work in southern Ontario clinics specializing in offering gender-affirming treatments to minors and older youth (12-25 years of age). I interviewed two pediatricians from the Transgender Youth Clinic at the Hospital for Sick Children in downtown Toronto, and one family doctor from Quest Community Health Care in Windsor who is a trans woman herself. One of the physicians was a racialized gay man. Both of the well-resourced clinics treat gender variance as a physical condition not a pathology, making them progressive clinics. All three doctors described the importance of access to gender-affirming treatments for trans youth. All three emphasized the life-saving effect that puberty blockers can have for youth between 10-15 years. Both clinics have long waiting lists and describe high volumes of patients demonstrating need.⁶⁷ All three told me however, that most of their patients were white, middle to upper-class and most attended the clinic with families possessing employee health benefits. They could not explain this racial disparity. Both white doctors surmised that it had to do with inadequate support or lack of consent from racialized parents perhaps due to cultural or religious reasons.

The critical aim of this thesis then is to discover how and why, if race and transness are so intertwined, trans racialized youth are erased from media reports, from research, clinical access, and from jurisprudence. In the next section I will create a picture of trans racialized youth and access to health in Ontario.

⁶⁷ Adam Carter, "Hamilton a desert for transgender healthcare, but hope is on the horizon", CBC News (1 March 2017), online: <<https://www.cbc.ca/news/canada/hamilton/transgender-healthcare-1.4003071>>.

A Research Portrait of Trans Racialized Youth in Ontario

Existing literature on access to health care for trans racialized youth is quite limited and the brushstrokes of research depict an environment of professional ignorance and discrimination.⁶⁸ The 2009 Trans PULSE study was the first Canadian research series about trans communities. Trans PULSE hired trans researchers and used mixed-methods. As a result, Trans PULSE was able to collect data about youth and racialized people and newcomers. Trans PULSE documented that out of approximately 53,500 trans people in Canada, one-quarter of them identify as racialized, while one out of 14 identify as Indigenous.⁶⁹ Trans PULSE also found that 34 per cent of trans Ontarians are 24 years and under, and detailed the unique vulnerabilities experienced by trans youth compared to their LGBTQ counterparts.⁷⁰ For example, the study found that 67 per cent of trans youth experienced significant family rejection⁷¹, homelessness and distressed mental health resulting in much higher rates of suicidal ideation and actual attempts than both their cis straight and cis queer counterparts.⁷² Furthermore their results indicated the particular vulnerability of trans youth compared to trans adults. Trans youth (up to 24 years) were almost

⁶⁸ Shanna K Kattari et al, “Racial and Ethnic Differences in Experiences of Discrimination in Accessing Health Services Among Transgender People in the United States” (2015) 16:2 Int J Transgenderism 68 at 72, 74–75. This study re-analyzed the 2010 National Discrimination Survey data for differences in health care experiences of discrimination between 4,879 White trans people and 1572 trans people of colour disaggregating data into 5 racial categories. It considered three health service areas: doctors and hospitals, emergency rooms, and in ambulances and emergency medical technicians. Their findings showed that Latinx trans and biracial/multiracial people experienced significantly higher rates of discrimination than white trans people in all three categories.

⁶⁹ Online Trans PULSE <<http://transpulseproject.ca/research/intersecting-impacts-transphobia-racism-hiv-risk-among-trans-persons-colour-ontario-canada/>>.

⁷⁰ Greta Bauer et al, Impacts of Strong Parental Support for Trans Youth, TransPULSE (Toronto, Ontario: Children’s Aid Society of Toronto and Delisle Youth Services, 2012) at 3–4.

⁷¹ *Ibid*, at 2.

⁷² Bauer Greta, et al, “Suicidality among Trans People in Ontario/ La suicidabilité parmi les personnes trans en Ontario”, online: Trans PULSE <<http://transpulseproject.ca/research/suicidality-among-trans-people-in-ontario-la-suicidabilite-parmi-les-personnes-trans-en-ontario/>>.

twice as likely to seriously consider suicide as those over 25, and almost three times as likely to have attempted suicide within the past year.⁷³ Another key finding was that trans people avoided primary care and emergency health services due to a striking lack of competent and sensitive services.⁷⁴ For example, Namaste's pioneering research on trans people's experiences with Canadian Gender Identity Clinics (GICs) showed that endocrinologists refused cross-sex hormone therapy for trans people when it was almost the same process as hormone replacement therapy for cis people. Endocrinologists who did prescribe hormones to trans people refused to monitor them or did not know how to dose trans people properly resulting in negative side effects.⁷⁵ U.S. studies of how trans people relate to health care access noted patterns such as: concealing gender from health care providers and staff; educating health care providers about health care needs and issues; avoiding primary care and relying on emergency medical care; or avoiding health care services altogether.⁷⁶ U.S. researchers also noted race as a correlate in increased emergency medical use and increased discrimination when trans people of colour use emergency services.⁷⁷

While not intentionally attending to race or ethnicity, Hammond's study of the social organization of trans youth health care drew attention to the levels of autonomy of trans youth

⁷³ Greta Bauer, et al, "Suicidality among Trans People in Ontario/ La suicidabilité parmi les personnes trans en Ontario", online: Trans PULSE <<http://transpulseproject.ca/research/suicidality-among-trans-people-in-ontario-la-suicidabilite-parmi-les-personnes-trans-en-ontario/>>; Kyle Scanlon et al, Ontario's Trans Communities and Suicide: Transphobia is Bad for Our Health, Trans PULSE E-Bulletin Vol 1, Issue 1 (Toronto, Ontario, 2010).

⁷⁴ Ayden I. Scheim et al, "Reported Emergency Department Avoidance, Use, and Experiences of Transgender Persons in Ontario, Canada" (2013) Trans PULSE, online: <<http://transpulseproject.ca/research/reported-emergency-department-avoidance-use-and-experiences-of-transgender-persons-in-ontario-canada/>>.

⁷⁵ Viviane K Namaste, "Access Denied: The Experiences of Transsexuals and Transgendered People with Health Care and Social Services in Toronto" in *Invisible Lives Erasure Transsexual Transgendered People* (Chicago, Illinois: University of Chicago Press, 2000) 157 at 168.

⁷⁶ Kattari et al. *supra* note 68 at 68.

⁷⁷ J Grant et al, *Injustice at Every Turn: A report of the National Transgender Discrimination Survey* (Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force, 2011) at 73.

within the two types of service delivery systems at The Centre for Addiction and Mental Health (CAMH) and Sherbourne Health Centre (SHC).⁷⁸ Secondly, her work explored how trans youth identity formation defied categories imposed by the medical model of transness.⁷⁹ Youth from across Ontario detail the painful impacts of experiencing delays for appointments and treatment, paying out of pocket for sexual deviance testing, having to participate in research to access services, receiving transphobic and/or incompetent services or being denied services altogether.⁸⁰ Youth discussed avoiding the CAMH GIC due in part to requirements to prove gender identity through the real life test.⁸¹ Disaggregated research showed that transfeminine, racialized and underhoused or homeless trans people in Ontario were more likely not to have a family physician than other trans people.⁸² In order to survive, trans youth worked tenaciously to secure housing, pool health information, share hormones, heal from family rejection or manage family expectations, actualize their gender expression, and make a living.⁸³ Hammond's attention to local resilience, agency and autonomy practices of trans youth influenced the direction of my research. I geared my specific inquiry towards the ways that statutes, policy and authoritative texts erode or foster agency and autonomy as forms of decision making in health.

⁷⁸ Rebecca Hammond, *The Social Organization of Health Care for Trans Youth in Ontario* (Master of Science Public Health, Dalhousie University, 2010) [unpublished] at 6.

⁷⁹ Hammond used institutional ethnography and in-person interviews to describe the realities of 21 trans youth between the ages of 16-25 in Toronto as they accessed health care related to transitioning. Data on race/ethnicity was not collected.

⁸⁰ Hammond *supra* note 78 at 96, 97, 101, 102.

⁸¹ *Ibid* at 86.

⁸² Ayden I Scheim et al, "Disparities in access to family physicians among transgender people in Ontario, Canada" (2017) 18:3 Int J Transgenderism 343 at 350; For suggestion that self-reported transphobia and racism increased vulnerability to HIV infection. See also Roxanne Longman Marcellin, Greta R Bauer & Ayden I Scheim, "Intersecting impacts of transphobia and racism on HIV risk among trans persons of colour in Ontario, Canada" (2013) 6:4 Ethn Inequalities Health Soc Care 97 at 102–103.

⁸³ Hammond, *supra* note 78 at 1,5,130-131; See also Nooshin Khobzi Rotondi et al, "Nonprescribed Hormone Use and Self-Performed Surgeries: 'Do-It-Yourself' Transitions in Transgender Communities in Ontario, Canada" (2013) 103:10 Am J Public Health 1830 at 9–10 using the TransPULSE data set with 33 per cent youth and 12 per cent racialized participants.

Yan retrieved the voices and experiences of Toronto trans racialized youth in her secondary analysis of the 2008 Toronto Teen Sex Survey data, which had been disaggregated by race and gender identity.⁸⁴ Eighty-five per cent of the 1216 participants were Black and South Asian and some of them were immigrant and newcomer youth whose voices are typically unrepresented in Canadian research. Yan's work highlighted the impacts of racism, language barriers and conservative religious norms on newcomer and racialized youth who did not have the privilege of "coming" out into an LGBTQ community that reflected or welcomed them. Yan's work filled in the picture of racialized youth who juggled religious and cultural expectations⁸⁵ with meager financial resources for transitioning,⁸⁶ complicated family supports and a desire for services in their languages that respected their confidentiality in sexual health decision making. Trans youth-specific findings were: they were not actually being served for trans specific health needs or in trans competent ways when aggregated with LGBQ youth (for example being misgendered), they were assumed to be gay/queer, and there was a lack of sensitivity to trans youth's fear of being physically examined.⁸⁷ It was significant that beyond simply enumerating the negative interpersonal attitudes of service providers and continuing the institutional analysis trend, Yan fleshed out institutional patterns in social services that created vulnerability to racism and transphobia.⁸⁸

⁸⁴ Shanshan Yan, *Through an Intersectionality Lens: Service Provider Views On The Sexual Health Needs Of Racialized LGBTQ Youth In Toronto* (Masters Thesis, Wilfred Laurier University, 2014) [Unpublished].

⁸⁵ *Ibid* at 31–33.

⁸⁶ *Ibid* at 36.

⁸⁷ *Ibid* at 49–52.

⁸⁸ Namaste called for institutional research and change 19 years ago in Namaste 2000 *supra* note 75; see also Leslie Feinberg, "Trans health crisis: For us it's life or death" (2001) 91:6 Am J Public Health Wash 897; the institutional neglect of trans health was taken up again by Greta R Bauer et al, "I Don't Think This Is Theoretical; This Is Our Lives?: How Erasure Impacts Health Care for Transgender People" (2009) 20:5 J Assoc Nurses AIDS Care 348.

While researchers continued to mine the same 2009 data set for intersectional nuances, subsequent national studies of trans youth were structured in ways that prevented the participation of trans racialized youth and did not attempt to disaggregate data by race and ethnicity.⁸⁹ These oversights are troubling since research had suggested that trans racialized youth were more structurally vulnerable to health neglect and secondly they understood themselves to be phenomenologically different from white youth.⁹⁰ Fortunately, more accurate data about trans racialized youth in Ontario is available from two very recent studies that I will discuss in turn. The Transforming Justice survey conducted identity-based focus groups between 2016 and 2017 for trans youth, racialized trans people, and Two-spirit people.⁹¹ The survey found that medical problems were the second highest legal problem affecting 25 per cent of trans people, compared to 2.6 per cent of Canadians.⁹² The biggest legal problem for trans people was discrimination, which included discrimination in health care.⁹³ Participants described multiple layers of transphobia starting in their youth with abusive families and parents who blocked them from getting name changes, hormone therapies and other trans specific medical procedures despite the lack of an age threshold for decision making in the *HCCA*.⁹⁴ Youth participants also

⁸⁹ Shauna M Lawlis et al, “Health Concerns of Transgender and Gender Nonconforming Youth and Their Parents Upon Presentation to a Transgender Clinic” (2017) 61:5 J Adolesc Health 642 at 643 This is the first published research on this topic, took place at a hospital clinic in the U.S. Midwest with no race/ethnicity or income/class data collected. J Veale, H Frohard-Dourlent & S Dobson, *Being Safe, Being Me* (Vancouver, BC: Stigma and Resilience among Vulnerable Youth Centre, University of British Columbia, 2015) was first Canadian trans youth specific survey on health and healthcare, the respondents were primarily white and urban. Aggregated quantitative study on discrimination in schools, EGale surveyed 3700 LGBTQ students across Canada between 2007-2009 Catherine G Taylor & Tracey Peter, *Every class in every school: Final report on the first national climate survey on homophobia, biphobia, and transphobia in Canadian schools* (Egale Canada Human Rights Trust, 2011).

⁹⁰ Gutierrez, *supra* note 50; Singh 2013a, *supra* note 50; Singh et al 2014, *supra* note 50.

⁹¹ Nicole Nussbaum, et al, *supra* note 28 Discussion questions asked about frequency and types of discrimination, justiciable legal problems and legal remedies sought. Findings were compared to the experiences of non-trans Canadians over the same 3 years time period. .

⁹² At 6 and 9.

⁹³ Nicole Nussbaum, et al, *supra* note 28, fig 1.

⁹⁴ At 8.

described systemic discrimination in schools, and in child welfare institutions.⁹⁵ Housing and shelter systems were especially bad for example, because they are segregated by both natal sex and gender presentation.⁹⁶ When violence occurred in the shelter, trans victims were blamed for it and staff held no one accountable.⁹⁷ Trans youth, who have very high rates of homelessness in the Greater Toronto Area,⁹⁸ spoke about using street-based means to obtain hormones, money, shelter and to build safety networks that replaced biological family support and protection.⁹⁹

Racialized trans participants from Transforming Justice revealed the challenges of surviving at the intersections of race and transness in the following ways: experiencing racism and transphobia within mainstream and LGBTQ mainstream social services; and a lack of trust in the legal system. They described making agentic choices to manage racism and transphobia such as: avoiding medical services within their own cultural communities; looking outside their own ethnocultural communities for housing and employment.¹⁰⁰ In addition, Two-Spirit and trans Indigenous focus group participants emphasized the ongoing effects of colonization such as geographic and cultural dislocation. One example of colonialism and transphobia was the deployment of Christian settler ideologies against Two-spirit people in white adoptive homes, churches and through schooling.

Across all health care contexts, trans youth in the Transforming Justice study had experiences of being outed as trans, being misgendered or dead-named. Delays in emergency medical

⁹⁵ Lorraine Gale & Haley Syrja-McNally, “Expanding the Circle: Serving Children, Youth and Families by Integrating Gender Diversity and Affirming Gender-Independent Children” in Meyer, Pullen-Sansfaçon & Manning, *supra* note 53, 285 at 288.

⁹⁶ Nicole Nussbaum, et al, *supra* note 28 at 10.

⁹⁷ *Ibid* at 11.

⁹⁸ Alex Abramovich, “No Safe Place to Go - LGBTQ Youth Homelessness in Canada: Reviewing the Literature” (2012) 4:1 Canadian Journal of Family and Youth / Le Journal Canadien de Famille et de la Jeunesse.

⁹⁹ Nicole Nussbaum, et al, *supra* note 28 at 6, 8, 10, 12; Rotondi et al, *supra* note 84 at 9–10.

¹⁰⁰ *Ibid* at 9.

treatment and urgent care or outright refusals were common as was the experience of having all health issues viewed as trans-related or trans-caused all of which prompted trans people to avoid seeking urgent or primary care.¹⁰¹ With respect to medical treatment, participants related the following: denial of hormone replacement therapy and gender affirming surgeries and overall lack of trans competent healthcare. Almost no participant sought legal advice let alone taking legal action for any of the rights violations they experienced.¹⁰² Participants perceived legal information spaces and staff as inaccessible and daunting. It has been established that in Ontario, minors and older youth do not know their rights in terms of health law, often believing that doctors are required to consult their parents/guardians about serious health decisions.¹⁰³ The stakes of ignorance of the law are higher for trans and gender-expansive youth who have more reason for medical interactions, because fear of their parents finding out or blocking their choices could result in delayed or missed care and severe mental health consequences as was established earlier in this chapter.¹⁰⁴ Given the finding that youth relied on health care providers to share health rights information, rather than on school staff or peers, professional ignorance is troubling given Pyne's current research results, discussed below, about racial disparities in access to health clinics serving youth. That even today, internet savvy trans racialized youth urgently need health

¹⁰¹ *Ibid* at 9.

¹⁰² *Ibid* 10.

¹⁰³ K, Catton V, Farrer, W, Graham, University of Toronto: Centre for Urban and Community Studies, *Child in the City Programme. Adolescent beliefs and practices regarding the law of minors' medical consent: a pilot study*. Toronto: The Child in the City Programme and The Centre for Urban and Community Studies, University of Toronto; 1980. 100 p. (Child in the City report, no. 7) at 69. Catton interviewed 61 English-speaking 12-17-year olds, of which 20 per cent were born outside Canada, 57 per cent were between ages of 16-17 years old, and 80 per cent were female. Catton does not mention gender identity or race/ethnicity, Catton at 17. See also P. Alderson *Every day and medical life choices: decision making among 8-15-year-old school students*, in Michael Freeman, ed. *Children, medicine and the law*, 445 where the most common answers from minors about at what age they could consent to surgery were at 16 or 18 years old regardless of actual legal thresholds at 457.

¹⁰⁴ *Ibid* at 69.

consent law information will be borne out later on in the structural inadequacies of the *HCCA* in Chapter 4 and the focus groups' findings from trans racialized youth in Chapter 5.

The second recent study that focused on the attitudes of clinicians and community workers who provide services to trans youth confirms that it is predominantly white trans youth who benefit from the most progressive health services in Ontario.¹⁰⁵ While Pyne specifically studied the disparities between minors accessing puberty-blockers, his data does bring to light two key generalizable findings about clinicians who treat trans youth: they do not integrate an anti-racist approach to their practice with trans youth, and they assumed that racialized and immigrant families' communities were more transphobic than white communities.¹⁰⁶ Both findings reinforced my rationale for an inquiry into the relationship between trans racialized youth and autonomy experiences in health care decision making.

Similar to the informal interview results with my three southern Ontario doctors, Pyne's analysis confirmed that "gender affirming" doctors treating youth did not notice the whiteness of their patient demographics and when asked specifically about demographics, 100 per cent of clinicians described their patients as "majority white".¹⁰⁷ Notably, clinicians attributed the absence of trans racialized youth to deficiencies in racialized, immigrant communities with an emphasis on those practicing Christian and Muslim faiths.¹⁰⁸ In contrast to frontline youth workers, clinicians were ignorant to the ways in which the after effects of colonialism, and current consequences of globalization, war, immigration and migrant labour have affected the

¹⁰⁵ Pyne 2018 *supra* note 34 at 19, Pyne interviewed 18 clinicians who he identified as "affirming" of gender expansiveness, at 16.

¹⁰⁶ *Ibid* at 20.

¹⁰⁷ *Ibid* at 19.

¹⁰⁸ *Ibid* at 20.

kinship structures of racialized families and communities.¹⁰⁹ Parents and families of trans racialized youth are more likely struggling to survive with far less time and financial resources to support their child's questioning or transitioning than middle class and white families.¹¹⁰

Now it is widely accepted that having supportive parents or even one supportive adult improves the life chances and outcomes for trans and gender expansive youth.¹¹¹ Claims from the sparse and quantitative research about racialized and/or immigrant families' attitudes towards trans and gender expansive children and youth are inconclusive. U.S. Latinx youth reported experiencing less acceptance from their families than white youth.¹¹² While a national U.S. survey found Black, Latinx, Asian and American Indian respondents scoring higher for family acceptance of transness than white respondents.¹¹³

As we have already seen, particularly but not solely in the U.S. context, parents have been documented as regularly preventing minors and youth from transitioning for a wide variety of reasons.¹¹⁴ Yet if the *HCCA* allows capable people of any age to determine their treatments, how have parents alone been able to prevent racialized youth from accessing transition services?

Foregrounding Pyne's second finding let us return to consider the knowledge and practices of

¹⁰⁹ Lee, *supra* note 53 at 94.

¹¹⁰ *Ibid* at 100 Lee explains structural conditions that thwart families of colour from supporting trans youth; Manning and Asano note that an overwhelming number of parents doing gender advocacy for trans youth are white middle-class mothers, in Manning and Asano at 186; for a first-person narrative on struggle of Black single mother with trans child see Wendall D. Glenn. "For colored girls only": Reflections of an emerging male-to-female transgender and gender variant youth consciousness, in Mallon *supra* note 27, 104–14.

¹¹¹ C. Ryan, et al. (2010) 'Family Acceptance in Adolescence and the Health of LGBT Young Adults', *Journal of Child and Adolescent Psychiatric Nursing*, 23(4), pp. 205–213. T Young Adults', *Journal of Child and Adolescent Psychiatric Nursing*, 23(4), pp. 205–213. Greta Bauer et al, *Impacts of Strong Parental Support for Trans Youth*, TransPULSE (Toronto, Ontario: Children's Aid Society of Toronto and Delisle Youth Services, 2012).

¹¹² C. Ryan et al, "Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults." *Pediatr* 2009 Jan 123:1346–52.

¹¹³ Grant et al, *supra* note 77 at 88, 94.

¹¹⁴ Cole Thaler, Flor Bermudez & Susan Sommer, "Legal advocacy on behalf of transgender and gender nonconforming youth" in Mallon, *supra* note 27 at 151.

Ontario doctors, around consent law not just transness. Only two Ontario studies have examined Toronto doctors for awareness of the law regarding minor youth.¹¹⁵ The first found in 1979 that, of 29 surveyed, 41 per cent were unsure of the law, 14 per cent said they did not care about the law, 28 per cent said they could not treat a minor without a parent's consent and only 7 per cent said they would treat a sufficiently capable minor.¹¹⁶ When asked to list and rank factors they consider when treating minors, 52 per cent misunderstood health consent law, citing the seriousness of the issue as the number one factor to consider, then age and then the dependency of the youth on their family.¹¹⁷ Notably, these doctors felt that law was irrelevant to their practice and their knowledge of law did not impact their delivery of services to youth.¹¹⁸ The study concluded that youth, especially legally capable minors, were prevented from making treatment decisions due to the ignorance of doctors, and resources were needed to teach doctors health consent law to support autonomy of minors.¹¹⁹

If I connect these findings to the claims established in this chapter that trans racialized youth are not accessing specialized clinics or most LGBTQ services, that clinicians do not deliver services through an anti-racist lens, and that many local doctors serving minor youth do not understand the health consent legal rights of youth, it appears that trans racialized youth face a maze of obstacles on top of their structural vulnerability to poverty and being underhoused. They must first find the clinic, access the clinic, have a doctor find them capable of decision making,

¹¹⁵ Catton, K., Graham, W., Koulack, E. & Child in the City Programme. Doctors' understanding of and practices regarding the law of minors' medical consent: a pilot study. (The Child in the City Programme and the Centre for Urban and Community Studies, University of Toronto, 1979), and Urman, R., Dickens, B. & Harrison, C. Pediatric Health Care Physicians' and Surgeons' Views of Ontario's Health Care Consent Legislation Comments. *Health L.J.* 4, 135–150 (1996). I discuss the 1996 study in Chapter 4 in relation to the enactment of the *HCCA*.

¹¹⁶ Catton 1979 *ibid* at 22.

¹¹⁷ Catton 1979 *ibid* at 23 and 63.

¹¹⁸ Catton 1979 *ibid* at 63-64.

¹¹⁹ Catton 1979 *ibid* at 52.

and then convince a health care practitioner, most likely a psychiatrist, that they are “trans enough” to get diagnosed with Gender Dysphoria. Furthermore, as I will explicate through my analysis of authoritative clinical texts in Chapter 4, youth must prove that they are stable enough financially, emotionally, psychologically and logistically to medically transition in order for OHIP to cover the costs of drugs, hormones and surgeries. This final section below lays out the background of the medical model of transness upon which the authoritative texts rely and against which this research project positions itself.

The Medical Model of Transness

This house was never built for us, but we have been expected to abide by its rules.
(Chang, 2016, pp. 45-52)

While 19th century tropical medicine explicitly used racial ontologies to study the plasticity of sex, in the 20th century clinical psychiatry took over as the site for sex/gender knowledge production. The research-based GIC became the locus and the medical model of transness was the result of this shift.

Trans historians have diligently chronicled the pathologization of transsexuality and transgenderism along with the rise and fall of North American gender identity clinics (GICs), including Toronto’s CAMH. The Clarke Institute of Psychiatry, which later became CAMH, opened a youth GIC in 1968 as part of the Toronto Project to study transsexualism for the first time in Canada.¹²⁰ Four hospitals took part in the Toronto Project including the Hospital for Sick Children. Denny provided extensive documentation of the clinical selection for “true”

¹²⁰ Unknown. Ontario Report: Toronto Group to Study Trans-sexualism. Canadian Medical Association Journal. 1969 Dec 27;101.

transsexuals that was cissexist and deeply misogynist. Denny documents how the hopeful, if not desperate, people of the 1960s onwards in the U.S. seeking treatment, mistook the GICs as treatment centres, not clinical research centres, and secondly, that the GIC staff (made up of psychiatrists, psychologists, internists and endocrinologists) did not recognize the needs of their patients and certainly did not center services around those needs.¹²¹ Williams chronicles the rise and fall of “disco sexology” – named for the outdated scientifically dubious and transphobic knowledges – produced by cissexual mental health professionals whose prolific publications influenced judges and policymakers.¹²² While they constitute rich sources of the interactions between TSTG people and GIC researchers, until recently, accounts of clinical encounters were presented as completely white and uncomplicated by racism.¹²³

Trans academic Sandy Stone published “The Empire Strikes Back: A Posttranssexual Manifesto”.¹²⁴ Stone critiques the term “wrong body”, a term, she argues, doctors rely on to define transsexuality as a disorder not a state of being.¹²⁵ Stone remarks on the phallogentric and gender binary fixation of physicians including American endocrinologist Harry Benjamin.

¹²¹ Dallas Denny, “The-Politics-of-Diagnosis and the Diagnosis of Politics: How the university-affiliated gender clinics failed to meet the needs of transsexual people” (1991) 1:3 *Chrysal* Q 9 at 12.

¹²² Williams, *supra* note 6; on the uncritical reliance of judges on medical diagnoses see Paula J. Caplan, Lisa Cosgrove, *Bias in Psychiatric Diagnosis* in Paula J. Caplan, Lisa Cosgrove, eds. (Lanham, Md: Jason Aronson); 2004. xix-xxxiii at xxv.

¹²³ Kusha Dadui, “Queer and Trans Migration and Canadian Border Imperialism” in *Marvelous Grounds Queer Colour Hist Tor* (Toronto: Between the Lines, 2018) 107.

¹²⁴ Sandy Stone. *The Empire Strikes back: A Posttranssexual Manifesto*. In: Julia Epstein, Kristina Straub, editors. *Body guards: the cultural politics of gender ambiguity* [Internet]. London: Routledge; 1991 [cited 2017 Aug 9] p. 280–304. The first formal critique of the medical model of transsexuality was published in the late 70s, authored not by a dissatisfied patient, but ironically as a diatribe by radical feminist Janice G Raymond, in *the transsexual empire: the making of the she-male* (Boston: Beacon Press, 1979). Raymond and other writers on the sociology of medicine insisted that transsexuals were duped consumers who did not exist outside of the medical and surgical construction of their bodies. Raymond further accused trans women of colonizing women’s bodies and then colonizing women’s spaces.

¹²⁵ Stone *ibid* at 13.

Notably, Stone mentions the whitewashing explicit and implicit in the creation of the category “transsexual” and its accompanying discourse.

Suddenly the old morality tale of the truth of gender, told by a kindly white patriarch in New York in 1966, becomes pancultural in the 1980s. Emergent polyvocalities of lived experience, never represented in the discourse but present at least in potential, disappear; the berdache and the stripper, the tweedy housewife and the mujerado, the mah'u and the rock star, are still the same story after all, if we only try hard enough.¹²⁶

Also remarking on race-privileged access to GICs, Black trans activist Ms. Major remembers Benjamin as someone who “didn’t like coloured girls”.¹²⁷ Non-normative trans people embodying non-Western white stories countered the limited clinical representations familiar to cis doctors and researchers but were likely to be rejected from GICs.¹²⁸ However as some conclude, the outcomes of the clinics should not be totally dismissed. The work of the clinics resulted in a diagnosis for Gender Identity Disorder in the *DSM-V*, the protocols of the Harry Benjamin Standards of Care and a base of medical scientific knowledge (still not widely shared or taught in medical schools) about gender-affirming treatments that had not existed before.¹²⁹

The debate over the merits and drawbacks of listing “gender dysphoria” in the *DSM-V* as the official diagnosis for transness turns on the pragmatic needs of marginalized trans people to

¹²⁶ Stone *ibid* at 10.

¹²⁷ Ophelian A. Diagnosing Difference [Internet]. Floating Ophelia Productions; 2011. Avail Ophelian A. Diagnosing Difference [Internet]. Floating Ophelia Productions; 2011. Available from: <<http://www.diagnosingdifference.com/>>.

¹²⁸ Stone was inspired by the work of Donna Haraway. Haraway authored the widely quoted 1985 “Manifesto for Cyborgs: Science, Technology and Socialist Feminism the 1980s”, mentored Stone and later became her supervisor for her doctorate. Stone’s manifesto was seen by many as the catalyst for Trans Studies as a field. She was the first academic to write about the imperialistic spread of the term “transsexual” and its accompanying diagnostic criteria as U.S. researchers and clinicians disseminated their “clinically good histories” of transsexuality, Stone *supra* note 125 at 10.

¹²⁹ Denny 1991 *supra* note 122 at 12 and Arlen Istar Lev. Transgender Emergence: Understanding Diverse Gender Identities and Experiences (2004).

access government subsidized services which require diagnoses versus the desire to not be labelled with mental illnesses.¹³⁰ The intricacies of the debate are beyond the scope of this paper. As I explore in Chapter 4, if meeting the diagnostic criteria from the *DSM-V* and other official clinical standards is the *only* way to get publicly funded treatment, then those rules determine *who* is trans and by extension who can live in their felt gender and more likely access identification and housing – but they also limit *how* a person might see themselves as trans.

Numerous scholars and empirical researchers have said: TSTG people were actually quite well informed about the criteria in the Harry Benjamin/WPATH Standards of Care (SoC) and the ways primary and gender-affirming health care was administered in Toronto.¹³¹ It is not surprising then that studies reveal that transsexuals without employment-related health insurance or independent wealth, or those who did not want to go through the painful rigours of the GIC, which rarely conferred surgical recommendation, made agentic choices to achieve body modification using income derived from sex work and/or D.I.Y. methods.¹³²

In conclusion, from the literature, it appears that trans racialized youth feel unassisted and even directly oppressed by medicine and law, two normative institutions of public life, that are supposed to provide structure, support and avenues of healing and redress to members of society.

¹³⁰ Namaste 2000, *supra* note 75; Pooja S Gehi & Gabriel Arkles, “Unraveling Injustice: Race and Class Impact of Medicaid Exclusions of Transition-Related Health Care for Transgender People, 4 SEXUALITY RES. & Soc. POL’Y 7, 12 (2007).” (2007) 4:7 SEXUALITY RES & Soc POL’Y 12; Madeline B Deutsch, “Gender-affirming Surgeries in the Era of Insurance Coverage: Developing a Framework for Psychosocial Support and Care Navigation in the Perioperative Period” (2016) 27 J Health Care Poor Underserved 386; Government of Ontario, “Gender confirming surgery”, (7 March 2016), online: Ontario.ca <<https://www.ontario.ca/page/gender-confirming-surgery>>.

¹³¹ Sandy Stone *supra* note 125; Dallas Denny, “In Search of the ‘True’ Transsexual” (1996) 2:3 Chrysal J Transgressive Gend Identities 39; Jay Prosser, *Second Skins: The Body Narratives of Transsexuality* (New York: Columbia University Press, 1998); Namaste 2000, *supra* note 75; Spade 2003, *supra* note 52; Kai Cheng Thom, “Not Born this Way: On Transitioning as a Transwoman Who Has Never Felt ‘Trapped in the Wrong Body’”, XoJane Womens Lifestyle Community Site - XoJane (9 July 2015), online: <<http://www.xojane.com/issues/im-a-transwoman-who-never-felt-trapped-in-the-wrong-body>>.

¹³² Namaste 2000, *supra* note 75 at 195. Namaste interviewed 19 trans people (17 MTFs and 2 FTMs, some of whom were sex workers and a few of whom were racialized). Rotondi et al, *supra* note 83.

There are holes in the knowledge of health care providers, especially physicians about gender affirming care and the health consent rights of minors and youth. Youth themselves seem uninformed of their rights under the *HCCA*, despite the high stakes of not accessing care at a pivotal transition time, which begs for an examination of the promises and mechanisms of the *HCCA*. And finally, in order to understand the relationship of trans racialized youth to autonomy in health care I need to create a space to hear from youth themselves.

Roadmap of Thesis

This chapter has provided the Canadian context for my research. There are barriers to being able to undergo physical changes for trans youth (if desired). There are social, legal and financial barriers to being able to live in one's gender identity and therefore fully actualize one's self - socially in particular. There are barriers to obtaining material independence due to high levels of discrimination. These barriers are heightened for racialized and Indigenous trans youth. Against this backdrop, my research question then is how do trans racialized youth experience autonomous and or agentic decision making in health care. To answer my research question, I juxtaposed visual and interview data from focus groups against an examination of a selection of legal materials. In Chapter 2 I explain the theoretical constructs I used including: intersectionality and structural vulnerability; examination of a relational theory of autonomy as well as the role of doctors, other health care providers and families with respect to that autonomy. Chapter 3 explains my methodology. I share my selection of data sources, collection and analytical methods for four categories of legal norms. I am committed to a pluralist epistemology where voices of trans racialized youth are heard. This is because a focus solely on

jurisprudence or statutes as sources, paints a picture of the lives of white mostly straight, adult, educated professional trans people, and tells us nothing about the law's effects on marginalized groups like trans racialized minors or youth who rarely litigate. In Chapter 4 I examine the attitudes of judges and decision makers towards autonomy in health care for trans minors and youth through their interpretation of common law and the *HCCA*. I also analyse authoritative diagnostic and clinical texts that determine who gets to be trans and assign the gatekeeping role for trans care to mental health professionals instead of primary care providers. In Chapter 5 I share the findings from my qualitative research with trans racialized youth between the ages of 18-25 years. Trans racialized youth have their own responses and strategies for navigating health care in Ontario, some of which could be protective reactions and some that could enable autonomous supported decision making. Chapter 6 contains my conclusions and policy recommendations for future change.

Chapter 2: Theory Frameworks and Analytical Tools

In this research project I rely upon theories that grapple with identity formation, visual expression and social locations that are relative, temporal and contextual. This chapter also investigates the concepts of selfhood, autonomy and agency that are central to my project, as they have been developed by selective writers in the fields of philosophy, feminist legal theory, social theory, anthropology and applied ethics. First, I begin with a brief discussion of *intersectionality theory* as an approach to coalesce trans racialized youth's multiple identities, experiences and responses to health care inequities. I then connect intersectionality to the related theory of *structural vulnerability* as a way to understand how institutions and systems relegate trans racialized youth to subordinate positions. In the second section, I lay out the conceptual groundwork for my argument about how to understand the decision-making experiences of trans racialized youth by contrasting the ideas of autonomy and agency. I specifically focus on a relational theory of autonomy. I consider how scholarship on relational autonomy accounts for selfhood, collective identity, race/ethnicity and gender that are situated in sociopolitical dynamics and also embodied. In the third section, I lay out Muñoz's *disidentification*, a theory for the artistic practices, products and interpretations by marginalized queers in response to lack of cultural representation or misrepresentation.¹³³ Disidentification will be used to analyze the photographic essays created by trans racialized youth in Chapter 5. Lastly, in the fourth section I describe *Transgender Theory*, developed by Nagoshi and Bruzuzy in 2010.¹³⁴ This theory builds

¹³³ Jose Esteban Muñoz, *Disidentifications: Queers of Colour and the Performance of Politics*, Cultural Studies of the Americas (Minneapolis: University of Minnesota Press, 1999).

¹³⁴ Julie L Nagoshi & Stephann/ie Bruzuzy, "Transgender Theory: Embodying Research and Practice" (2010) 25:4 *Affia* 431.

on and challenges feminist and queer theories of gender, integrating as key features: embodiment, socially-constructed gender, essentialism, and intersectional political solidarity. I use this gender theory to guide my qualitative research methods as required by Singh in her checklist for researchers which I explain in detail in Chapter 3.

Intersectionality

Patricia Collins, articulated the concept of intersectionality to mean “particular forms of intersecting oppressions, for example, intersections of race and gender, or of sexuality and nation”.¹³⁵ An intersectional framework can result in a more accurate analysis of how social factors determine health¹³⁶ because it accounts for *simultaneous* as well as *interacting* experiences of oppression.¹³⁷ Using an intersectional approach means that experiences linked to social identities can be understood as more than simply cumulative experiences.¹³⁸ While an “add-on” view of multiple oppressions assumes that people with multiple marginalized group

¹³⁵ P. H. Collins (2000). Black feminist thought: Knowledge, consciousness, and the politics of empowerment. New York: Routledge. Collins refined the concept coined by critical legal theorist Kimberlé Crenshaw in Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. Stanford Law Review, 43(6), 1241-1241. Black and lesbian of colour feminists and writers have theorized their experience of multiple identities and therefore multiple oppressions since the 1970s. Cherrie Moraga & Gloria Anzaldua, This bridge called my back: writings by radical women of color (Watertown, MA: Persephone Press, 1981); Audre Lorde & Black Women Writers - York University, Sister outsider: essays and speeches, Black women writers (Trumansburg, NY: Crossing Press, 1984); Gloria T Hull, Patricia Bell Scott & Barbara Smith, All the women are white, all the blacks are men, but some of us are brave: black women's studies (Old Westbury, NY: The Feminist Press, 1982).

¹³⁶ The concept of social determinants of health was developed by the World Health Organization, see Commission on Social Determinants of Health, Closing the Gap in a Generation: Health Equity through action on the social determinants of Health, Final Report: Executive Summary (Geneva: World Health Organization, 2008).

¹³⁷ L. Bowleg (2012). The Problem with the Phrase Women and Minorities: Intersectionality-an Important Theoretical Framework for Public Health. American Journal of Public Health, 102(7), 1267-73.

¹³⁸ D. King (1990). Multiple jeopardy, multiple consciousnesses: The context of a black feminist ideology, in M. Malson, E. Mudimbe-Boyi, J. O'Barr, & M. Wyer (Eds.), Black women in America: Social science perspectives, (pp. 265-295). Chicago, IL: University of Chicago Press.

identities experience oppression as a sum of the distinct discriminatory experiences, intersectionality theory instead says that they experience oppression *uniquely*.¹³⁹

Intersectionality as a hermeneutic has implications for methodology. As a theoretical framework it can lift methodology out of the pitfalls of victimhood and oversimplified identity politics.¹⁴⁰ For example, rather than only comparing experiences of oppression or discrimination, intersectionality requires the consideration of privilege and fortunate circumstances.¹⁴¹ Furthermore, intersectionality recognizes the qualitative differences between identities.¹⁴² To illustrate, a person can become disabled by an accident or by aging, similarly a person's class might change through professional mobility, whereas their race and ethnicity will not change. Intersectional research design then must attend to the fact that participants may not be able to tell which of their characteristics is driving discrimination.¹⁴³ Results of a national U.S. survey on transphobia showed that white trans people experienced higher rates of transphobia than black trans people in some healthcare contexts.¹⁴⁴ The Trans Legal Needs survey is a local example of this phenomenon, where trans participants of colour expressed difficulty in separating out racism and transphobia when answering questions about experiences of transphobic discrimination.¹⁴⁵

¹³⁹ Lisa Bowleg, "When Black + Lesbian + Woman ≠ Black Lesbian Woman: The Methodological Challenges of Qualitative and Quantitative Intersectionality Research" (2008) 59:5–6 *Sex Roles* 312; Feminists like Julia Serano and Moya Bailey have forged terms like "transmisogyny" and "misogynoir" in attempts to precisely characterize intersectional experiences of oppression. Julia Serano, *Whipping Girl: A Transsexual Woman on Sexism and the Scapegoating of Femininity* (Seal Press, 2009) at 15; Marie Solis, "Meet Moya Bailey, the black woman who created the term 'misogynoir'", (30 August 2016), online: Mic <<https://mic.com/articles/152965/meet-moya-bailey-the-black-woman-who-created-the-term-misogynoir>>.

¹⁴⁰ Umut Erel et al, "On the Depoliticisation of Intersectionality Talk: Conceptualising Multiple Oppressions in Critical Sexuality Studies" in *Theor Intersect Sex, Genders and Sexualities in the Social Sciences* (Palgrave Macmillan, London, 2010) 56 at 281–282.

¹⁴¹ *Ibid*.

¹⁴² S. A. Shields, (2008). *Gender: An Intersectionality Perspective*. *Sex Roles*, 59(5-6), 301–311.

¹⁴³ Shanna K Kattari et al, *supra* note 68 at 75.

¹⁴⁴ *Ibid*.

¹⁴⁵ Nussbaum et al *supra* note 28 at 7.

Although it is not practical or possible to consider an exhaustive list of intersecting identities, if research questions are designed and disseminated inclusively enough, all identity dimensions can be accessed, acknowledged and analyzed throughout the project.¹⁴⁶

Lastly, intersectionality is aware of the nuanced and shifting multiple identities of people, which is critical for working with trans racialized youth who might transition more than once and in more than one context (medical, social, legal).¹⁴⁷ In conclusion, the theory of intersectionality captures how all of the dimensions of one's identity shape one's understanding and experience of a situation and affect the nature of the decisions and actions that follow. The conditions for autonomous behaviour are deeply connected to our multi-dimensional identities. We will see next how institutional, interpersonal and discursive structures produce vulnerability for trans racialized youth that affect their practice of autonomy.

Structural Vulnerability

Structural vulnerability is a concept derived from Galtung's theory of "structural violence".¹⁴⁸ It describes a subordinated position in a hierarchical society caused by being a member of more than one oppressed group, where multiple networks of power permeate social, personal, environmental, and legal realms causing stress and shortening one's lifespan.¹⁴⁹ According to medical anthropologists Quesada et al., cultural and social sources of stress include "(1) social

¹⁴⁶ Bowleg 2012, *supra* note 138.

¹⁴⁷ *Ibid*; see also recent work by Julia Temple Newhook et al, "A critical commentary on follow-up studies and 'desistance' theories about transgender and gender-nonconforming children" (2018) 19:2 International Journal of Transgenderism 212 at 213, 216, 219-220.

¹⁴⁸ Galtung J. (1969) Violence, peace and peace research Journal of peace research 6(3):167-191, at 183.

¹⁴⁹ James Quesada et al, "Structural Vulnerability and Health: Latino Migrant Laborers in the United States" (2011) 30:4 Med Anthropol 339 at 342, 351.

hierarchies scaffolded by categories bestowing entitlement; (2) historically distinctive discourses of normativity and ethics; and (3) the intersection of individual medical pathology and biography with social exclusion.¹⁵⁰ I will relate each of Quesada's points to the structural vulnerability of trans racialized youth. Firstly, categories like gender/sex, and race exist in law and medicine and buttress sociopolitical hierarchies of capitalism, ableism and patriarchy by determining access to housing, education, and health care. Secondly, professional norms for dealing with trans racialized youth build on epistemologies of transsexuality and transness established discursively over centuries through medicine and law. Thirdly, Quesada et al. also include as structural vulnerabilities, the way a person's individual appearance, affect, voice, medical conditions and cognitive abilities are "read", i.e. by professionals within institutions and public spaces.¹⁵¹ This iterative and socially constructed element of an identity is extremely relevant for trans racialized youth as they move through the world, being assessed by cisgender health care providers who ultimately decide whether they can access the treatments they want. How the act of "reading"¹⁵² or ascribing race/ethnicity and gender categories to others can contribute to social exclusion and divided selfhood, is explored in greater detail in the following section on relational selfhood.

Incorporating intersectionality theory, Quesada et al. explain that "Experiences of vulnerability, however, are only partially shared across populations because they are shaped unevenly by specific status attributes (i.e., gender, age, ethnicity, etc.), conditions (i.e., legal

¹⁵⁰ For this analysis at 341-42 Quesada et al. rely on Pierre Bourdieu, *Pascalian meditations* (Stanford: Stanford University Press, 2000); and Michel Foucault "The ethics of the concern for self as a practice of freedom", in Michel Foucault, Paul Rabinow & Robert Hurley, *Ethics: subjectivity and truth*, Dits et écrits English Selections; v 1 (New York: New Press, 1997); João Guilherme Biehl, *Vita: life in a zone of social abandonment* (Berkeley: University of California Press, 2005).

¹⁵¹ Quesada et al, *supra* note 150 at 351.

¹⁵² Serano describes the practice of "reading" or "gendering" and its impact on her sense of self in Serano, *supra* note 140 at 164.

status, economic and living conditions, etc.), and individual serendipity.”¹⁵³ For example, some Black or Indigenous people may have grown up in foster care, and experienced different types of violence or racism than counterparts who grew up with their families of origin. On the other hand, someone who develops secondary sex characteristics that are closer to the gender presentation they desire will have less trouble being “read” by others as the gender they feel. A critical part of the intersectional approach is recognizing the heterogeneity of individual biographies of social exclusion and vulnerability within identity groups.

Oppression is often internalized by multiply and historically oppressed people over generations.¹⁵⁴ For example, they may understand themselves, or in other words, form their subjectivity, in relation to oppressive discourses that valorize productivity, heterosexuality, ability and whiteness. Their own narratives may reflect a sense of deficit or failure. And as a result, structurally vulnerable people often behave as though they deserve the ill health they experience especially where the discourse of neoliberalism has told members of society that they are responsible for all of their outcomes and that poverty or ill health is a result of their own deficiencies as entrepreneurs.¹⁵⁵ Structural vulnerability then, situates the pressures felt by people addressing health and health care that may influence their choices. Understanding their health care decision making process requires us to deconstruct the notions of choice and voluntariness that are central to the now legislated practice of informed consent. To do this, in the next section I will first unpack the concept of “autonomy” or self-governance through the

¹⁵³ Quesada *supra* note 150 at 346.

¹⁵⁴ *Ibid* at 352.

¹⁵⁵ Jennifer M Denbow, *Governed through Choice: Autonomy, Technology, and the Politics of Reproduction* (New York: NYU Press, 2015) at 104–105; Peter Miller & Nikolas S Rose, *Governing the present: administering economic, social and personal life* (Cambridge, UK: Polity, 2008) at 92.

lens of relational theory. I will then apply it to the health care context where autonomy is presented by Ontario's legislators and health care professionals as an animating principle.

Accounting for Autonomy

The principle of autonomy continues to infuse the field of bioethics currently affirmed by Canadian statutes, jurisprudence and scholarship. Still, traditional theories of personal and political autonomy have been widely criticized by feminists resulting in the reshaping of autonomy by some who wish to retain it as a value.¹⁵⁶ I map the development of a relational theory of autonomy arising from specific conceptions of the self, the collective and augment academic feminist relational theory with grounded theory by women of colour scholar activists from reproductive justice movements. This discussion includes a consideration of the relationship between reproductive autonomy and broader notions of autonomy for health care decision making, as well as Black women's and women of colour's critiques of reproductive autonomy in favour of reproductive justice. I use the reproductive justice movement as an example to demonstrate that in order to achieve autonomy producing conditions for structurally vulnerable people, we have to place equity and justice at the centre of autonomy struggles. In this way I consider autonomy as a practice that is socially and politically enabled, not a final destination for those with privilege.

¹⁵⁶ Jennifer Nedelsky, "Reconceiving Autonomy: Sources, Thoughts and Possibilities" (1989) 1:1 Yale J Law Fem 7 at 8 [Nedelsky 1998]; it is worth noting that Roberts does not totally discard libertarian autonomy because she sees it as beneficial for Black women and women of colour in two ways: it emphasizes self-definition and it can offer protection from state incursions on bodily integrity. Both could be useful strategic avenues. Dorothy E Roberts, *Killing the Black Body: Race, Reproduction, and the meaning of Liberty*, 1st ed. ed, Black women writers (New York: Pantheon Books, 1997) at 297; Susan Sherwin, *The politics of women's health: exploring agency and autonomy* (1998) at 32 [Sherwin 1998].

Traditional versions of autonomy are synonymous with either self-governance or liberty.¹⁵⁷ Roberts ascribes the subsequent North American libertarian reorientation of autonomy to Immanuel Kant's moral philosophy.¹⁵⁸ For Kant, rational independent agents still only follow laws they have created themselves or that they judge to be acceptable, but preventing state intervention is the central theme.¹⁵⁹ Liberty as a value and a practice did not guarantee equality for racialized and enslaved peoples. In this framework, rights act as negative liberty, in other words, freedom from undue democratic state limitations on their actions or property. The essential feature of personhood, in Kantian reasoning, was to be a rational, independent individual. In fact, if libertarian autonomy was elevated as an ideal, it served to valorize the choices of the most privileged who were white men with private property who constituted the government.¹⁶⁰

I will be examining a different conceptualization of autonomy derived from relational theory. The liberal atomistic person, in theory, derives their sense of self purely from their individual experiences and interests and ignorant to benefits or liabilities caused by their membership in

¹⁵⁷ Autonomy has its Western origin in the works of Jean Jacques Rousseau who used autonomy as the glue for the self-governing social contract made between man and society in which man sacrificed some of his individual liberty to become a member of a nation. Rousseau attempted to move from the goal of liberty as "freedom from interference" to political cohesion through the social concept of autonomy. Rousseau's autonomy involved submitting to laws of one's own creation in Jean-Jacques Rousseau, *The social contract*, Great ideas (New York: Penguin Books, 2006); Frederick Neuhoser, "Jean-Jacques Rousseau and the Origins of Autonomy" (2011) 54:5 *Interdiscip J Philos* 478.

¹⁵⁸ Roberts cites Kant as foundational in the American Constitution, ensuring that white men of property could build a nation with minimal state intrusion on their ability to act since they themselves devised Constitutional law in Roberts, *supra* note 157 at 295.

¹⁵⁹ Immanuel Kant laid out this philosophy in *The Groundwork of the Metaphysics of Morals*. Kant was influenced by Jean Jacques Rousseau who focused less on morals and more on political formations, less on liberty as freedom and more on social autonomy. Immanuel Kant, *The moral law: groundwork of the metaphysics of morals*, translated by H. J. Paton (London: Routledge, 1997).

¹⁶⁰ Roberts, *supra* note 157 at 297.

social groups.¹⁶¹ The starting point for relational theory, on the other hand, is that humans are constituted by their relationships. This includes relationships to oneself, and to family, friends, society, institutions and nation. Relationships may foster or undermine autonomy. Because of its implications for rights and justice, I use relational theory as a lens through which to argue that gaps in the *Health Care Consent Act* and related policies block the formation and growth of relationships of autonomy for trans racialized youth. Nedelsky, who theorized a relational version of autonomy and later popularized the concept of rights as relationships, considers what *positive* rights would mean for autonomy.¹⁶² Positive rights require governments and private actors to do more than protect people *from* one another.¹⁶³ For example if positive rights included the right to housing or the right to live in one's felt gender, governments would need to support conditions that actualized those rights. This would require nourishing relations conducive to practices of autonomy. To determine what those conditions are, let's look at what Nedelsky considers the ingredients for autonomy: self-determination, peace, security from oppression and power, confidence, dignity, efficacy, and respect.¹⁶⁴ It is easy to see how structurally vulnerable people would struggle to practice autonomy given that they experience daily attacks on their peace, security and confidence to say the least. The next section will focus on the formation of selfhood as a critical ingredient of autonomy.

The Relational Self

¹⁶¹ Stephanie J Kapusta, "Trans Authenticity and the 'Feminist Legacy' of Relationality" in Robert Scott Stewart, ed, *Talk Sex Multidiscip Discuss* (Sydney, NS: Cape Breton University Press, 2013) 146; Nedelsky 1989, *supra* note 157 at 8.

¹⁶² Nedelsky 1989, *supra* note 157.

¹⁶³ Jennifer Nedelsky, "Reconceiving rights as relationship" (1993) 1:1 *Rev Const Stud* 1 at 14 [Nedelsky 1933].

¹⁶⁴ Nedelsky 1989, *supra* note 157 at 11.

To govern oneself, one must be in a position to act competently in congruence with values, desires, goals and interests that are one's own.¹⁶⁵ Therefore an awareness of one's self is crucial to the exercise of autonomy.¹⁶⁶ A relational view of autonomy sees a person define their selfhood partly through the relationships they have with family members, professionals, institutions, cultural and political collectives and even non-human beings and also through their own internal essence.¹⁶⁷ Relationships that foster autonomy require equity, information exchange and personal growth. And yet, many of our relationships are embedded in the systems of oppression that make us structurally vulnerable. Therefore, relationships can also impede autonomy.

Selfhood also means being in touch with other building blocks of the self, such as by developing an awareness of one's cultural history, and group cultural practices. These augment and sometimes conflict with one's own individual values, needs, interests and goals.¹⁶⁸ Yet another way that the self is constituted is through social interactions where central traits such as gender and race which, as Oshana argues, are mostly socially ascribed to us by others.¹⁶⁹ Simply put, we are "read" by other people and this is how we are racialized or gendered. Oshana describes being alienated from a Blackness that is ascribed to her by others, and connects the experience to her biracial self-conception and her professional identity as an academic.¹⁷⁰

¹⁶⁵ Joel Anderson & John Christman, "Introduction" in John Christman & Joel Anderson, eds, *Autonomy and the Challenges to Liberalism: New Essays* (Cambridge, UK: Cambridge University Press, 2005) 1 at 3.

¹⁶⁶ Diana T Meyers, *Self, society, and personal choice* (New York, NY: Columbia University Press, 1989) [Meyers 1989]; Sherwin 1998, *supra* note 157 at 35; In this later work, Meyers offers a five dimensional account of selfhood with elements of unitary, relational, social, divided and embodied selves, see Diana Tietjens Meyers, "Decentralizing Autonomy: Five Faces of Selfhood" in Christman and Anderson, *supra* note 166, 27 [Meyers 2005].

¹⁶⁷ Nedelsky 1989, *supra* note 157 at 9.

¹⁶⁸ Andrew Sneddon, *Autonomy* (New York: Bloomsbury Publishing PLC, 2013) at 51–53; Diana Tietjens Meyers, *supra* note 167 at 29–31.

¹⁶⁹ Marina Oshana, "Autonomy and Self-Identity" in Christman and Anderson, *supra* note 166, 77 at 79; on how gender is read by cissexuals see Serano, *supra* note 140 at 164–165.

¹⁷⁰ *Ibid* at 92.

Primarily, she argues that anti-Black racism has limited her autonomy.¹⁷¹ And Serano speaks of her interrupted experiences of gender coherence and never taking her feminine gender for granted as a result of dysphoria and transphobia.¹⁷² With intersectional identities in mind, selfhood then, according to Oshana and Serano can be experienced as fragmented over race and gender respectively with impacts on autonomy. How trans racialized youth manage fragmented or cohesive selfhood in the context of health care is central to my analysis in Chapter 5.

While Shotwell and Sangrey agree that the self is neither purely socially constructed nor emerging from a purely internal source, they go further.¹⁷³ They theorize that while one's self is impacted by other people's ascriptions, similarly other people's selfhoods are impacted by our expressions of ourselves.¹⁷⁴ In other words, blackness shapes whiteness, and transness shapes cisgenderness. Selfhood can also then be understood as fluid and a process of self-awareness, rather than as a static state.¹⁷⁵ Indeed the iterative dynamic between one's self-conception (how one sees oneself) and how one is "read" or "labelled" is significant for the analysis of autonomy practices for structurally vulnerable trans racialized youth that I undertake in Chapter 5.

The Relationship between Oppression and Autonomy in Health Care

¹⁷¹ *Ibid.*

¹⁷² Serano, *supra* note 140 at 181.

¹⁷³ Alexis Shotwell & Trevor Sangrey, "Resisting Definition: Gendering through Interaction and Relational Selfhood" (2009) 24:3 *Hypatia* 56; for an author who views gender identity as internal and mostly pre-social and authenticity as necessary for autonomy see Lauren Bialystock, "Authenticity and Trans Identity" in Robert Scott Stewart, ed, *Talk Sex Multidiscip Discuss* (Sydney, NS: Cape Breton University Press, 2013) 122; and also Serano, *supra* note 140 at 6 who disagrees with Butler's theory of gender as purely socially constructed.

¹⁷⁴ Baylis, Françoise, "The Self in Situ: A Relational Account of Personal Identity" in Jocelyn Downie & Jennifer J Llewellyn, eds, *Relational Reflect Relational Theory Health Law*, 1 edition ed (UBC Press, 2012).

¹⁷⁵ Other autonomy theorists who agree with this position are Sherwin 1998, *supra* note 157 at 35; and even liberal autonomy theorists, Joel Anderson & John Christman, *supra* note 166 at 7.

Relational autonomy requires certain conditions to flourish: freedom from coercion, distance from social expectations, and knowledge of self. How then does oppression¹⁷⁶ impact one's sense of self, the selfhood that is so central to the exercise of autonomy? Choices and actions do not exist in vacuums where judgments can be made through a Rawlsian 'veil of ignorance'.¹⁷⁷ This is because, as Serano and Nedelsky argue, people are situated in complex lived and embodied contexts.¹⁷⁸ Without the conditions that enable one to pull away from normative roles and actions, it is challenging to make decisions that reflect one's needs, wishes and desires.¹⁷⁹ As I described earlier in this chapter, structural vulnerability leads to an erosion of confidence in self or self-trust which further undermines one's own autonomy.¹⁸⁰ Sherwin insists that, "In both health care and ethics the details of oppression must be prominently addressed."¹⁸¹ This statement is apt considering uneven power dynamics exist between health care providers and patients, manifested through bureaucratic policies, specialized education, language, income, social location and confidence.¹⁸² The earlier discussion of structural vulnerability illustrated

¹⁷⁶ I am considering "oppression" to be systemic, multidirectional and intergenerational as opposed to "discrimination" that I would characterize as individual, discrete and legally defined, as argued by both Iris Marion Young, *Justice and the politics of difference* (New Jersey: Princeton University Press, 1990) at 42–48; and Wendy Brown & Janet E Halley, "Suffering the Paradoxes of Rights" in Wendy Brown & Janet E Halley, eds, *Left legalism/left critique* (Durham: Duke University Press, 2002) at 426–427.

¹⁷⁷ John Rawls, *A Theory of Justice* (New York: Harvard University Press, 1974) at 11. Rawls argues that if rational agents were placed behind a screen where they did not know their social location, they would all agree on certain principles about basic liberties that guarantee those liberties when they subsequently realize their real location in a hierarchical society.

¹⁷⁸ Serano *supra* note 140 at 224-27; See also Jennifer Nedelsky, "Embodied Diversity and the Challenges to Law" (1996) 42 McGill L J 91 at 103.

¹⁷⁹ Oshana, *supra* note 171.

¹⁸⁰ Susan Sherwin, and Carolyn McLeod, "Relational Autonomy, Self-Trust and Health Care for Patients who are Oppressed" in Catriona Mackenzie & Natalie Stoljar, *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self* (Oxford University Press, 2000) 259-79 [Sherwin and McLeod].

¹⁸¹ Sherwin, *supra* note 158 at 12; Susan Sherwin, "Relational Autonomy and Global Threats" in Jocelyn Downie & Jennifer J Llewellyn, eds, *Relational Reflect Relational Theory Health Law*, 1 edition ed (UBC Press, 2012) 13 at 16–17.

¹⁸² Dorothy Roberts, "Reconstructing the Patient: Starting with Women of Colour" in Susan M Wolf, ed, *Fem Bioeth Reprod* (New York: Oxford University Press, 1996) 116 at 136 [Roberts 1996].

how oppression determines one's experience of health, through access to services, information and treatment options.¹⁸³ Multiply marginalized people often make choices that seem best given the circumstances but in the long-run only seem to comply with oppressive policies or leave oppressive systems in place.¹⁸⁴

To explain why structurally vulnerable people make contradictory choices against their own long-term interests or personal values, feminist theory has provided a helpful distinction between agency and autonomy.¹⁸⁵ At a basic level, autonomy has been described as making choices that reflect your values and personal and collective interests.¹⁸⁶ Whereas to exercise agency one need only receive adequate information, exercise reasonable choice without direct pressure. This lines up with bioethics requirements for informed consent, a discourse that equates agency (voluntary choice) with autonomy (self-governance).¹⁸⁷ In terms of agency, structural vulnerability factors create parameters for the choices people are aware of, feel they deserve and ultimately make, even as those choices are often judged by health care practitioners, social workers and academic feminists to be faulty.¹⁸⁸ Relational autonomy as I have explained it goes far beyond the voluntary choice to consent or refuse treatment suggested by one's doctor. Therefore, as I explain

¹⁸³ Commission on Social Determinants of Health, *supra* note 138 at 1.

¹⁸⁴ Sherwin and McLeod, *supra* note 181 at 268.

¹⁸⁵ Sherwin, *supra* note 158 at 17.

¹⁸⁶ Meyers, *supra* note 168 at 20; Tom L Beauchamp & James F Childress, Principles of biomedical ethics, 4th ed. ed (New York: Oxford University Press, 1994) at 125; James Rendtorff, "The Limitations and Accomplishments of Autonomy as a Basic Principle of Biomedics and Biolaw" in Tom L Beauchamp & James F Childress, eds, Princ Biomed Ethics, 4th ed. ed (New York: Oxford University Press, 1994) 75 at 78; Sneddon, *supra* note 170 at 5.

¹⁸⁷ Beauchamp & Childress, *supra* note 188.

¹⁸⁸ Roberts 1996, *supra* note 183; Kimala Price, "What is Reproductive Justice? How Women of Color Activists Are Redefining the Pro-Choice Paradigm" (2010) 10:2 Meridians Fem Race Transnationalism 42.

in more detail in Chapter 4, several feminist theorists argue that accepted bioethics procedures and policies of informed consent actually describe agency not autonomy.¹⁸⁹

From Autonomy to Justice

Autonomy has been one of the most influential concepts for feminist legal theorists and feminist philosophers because of its implications for holistic health, personal wellness and collective struggles for equity.¹⁹⁰ In autonomy scholarship, we see the tension between the individual and the collective.¹⁹¹ Social and political collectives can function as both nourishing and threatening to one's autonomy.¹⁹² If there is minimal autonomy where there are unjust social conditions,¹⁹³ Robert's argument that autonomy must be achieved through *justice*, requiring collective efforts to win rights protection or compel government action seems apt. Indeed, Indigenous, Black and women of colour activists have written, agitated and organized extensively in order to create the *conditions* for their own autonomy notably in the area of reproduction.¹⁹⁴ As Roberts emphasized, "the 'choice' rhetoric of the movement is problematic because it is based on a set of assumptions that applies only to a small group of women who are

¹⁸⁹ Roberts 1996, *supra* note 183; Susan Sherwin, *supra* note 158 at 12; Linda Barclay, "Autonomy and the Social Self" in Mackenzie & Stoljar, *supra* note 181, 52 at 54.

¹⁹⁰ Nelson, Erin. *Law, Policy and Reproductive Autonomy*, UK edition ed (Oxford); Portland, Oregon: Hart Publishing, 2013); and Jocelyn Downie, "Resistance Is Essential: Relational Responses to Recent Law and Policy Initiatives Involving Reproduction" in Jocelyn Downie & Jennifer J Llewellyn, eds, *Being Relational: Reflections on Relational Theory and Health Law*, 1 edition ed (UBC Press, 2012).

¹⁹¹ Nedelsky 1997, *supra* note 157; Diana Tietjens Meyers, *supra* note 168; Oshana, *supra* note 171.

¹⁹² Nedelsky 1993, *supra* note 164.

¹⁹³ Patricia Hill Collins, *Black sexual politics: African Americans, gender, and the new racism* (New York, NY: Routledge, 2004) at 4.

¹⁹⁴ These actions were necessitated by the fact that pro-choice movements and academic feminism did not actually reflect goals of or result in improved conditions for BIPOC communities.

privileged enough to have multiple choices.”¹⁹⁵ The intersectional nature of BIPOC women’s struggles for reproductive autonomy compelled the creation of an alternative theory and movement that could simultaneously account for the differences made by racism, classism, homophobia, and ableism.

Similarly, the constitutive and iterative relation between the self and others with respect to gender, has been used by some legal feminists to support the need for gender affirming surgeries for trans people who desire body modification for internal and external gender congruence.¹⁹⁶ Shotwell and Sangrey dispute the idea that trans people are the only ones who have a gender identity, and argue that both cis and trans people interact with each other’s gendered self-formation.¹⁹⁷ Shotwell and Sangrey stress the point that the current research focus on the gender identities of trans people flatten trans people’s experiences into a single dimension. Furthermore, the mainstream trans movement’s single-issue quest for individual rights to gender identity and gender expression rely on the libertarian atomistic view of autonomy.¹⁹⁸ This individualism is not the fault of individual trans people. Indeed, structurally vulnerable transsexuals are forced to engage with medicine and its coercive pathology to achieve gender affirmation. Furthermore, as we saw in the previous chapter, legal avenues for trans people to obtain identity documents, marital benefits, parental rights and so on all force them to squeeze into individualistic rights-based frameworks. However, I argue a relational theory of self, embedded in a relational

¹⁹⁵ Black women reproductive health scholar-activists, for example, coined the term “reproductive justice” in the early 1990s to call attention to and better address the ways Black women’s struggles for reproductive autonomy and freedom needed more than access to abortion and birth control.

¹⁹⁶ Dianne Pothier, “Relational Theory and Resource Allocation in Health Care: Accounting for Difference” in Jocelyn Downie & Jennifer J Llewellyn, eds, *Being Relational: Reflections on Relational Theory and Health Law*, 1 edition ed (UBC Press, 2012).

¹⁹⁷ Shotwell & Sangrey, *supra* note 175 at 59, 67; Kapusta, *supra* note 163; Pyne 2016, *supra* note 47.

¹⁹⁸ Shotwell & Sangrey, *supra* note 175 at 57–58; Dean Spade, “Laws as Tactics” (2011) 21 *Columbia J Gend Law* 40 at 56; Namaste, 2000, *supra* note 10.

understanding of autonomy would instead lead to a relational theory of rights. According to Nedelsky, rights recognize and define relationships that foster certain values beyond democracy and beyond autonomy. In Chapter 4 we return to rights as relationships as a useful concept for health care autonomy for trans racialized youth.

There are ways to resist the impact of oppression on one's health, and to minimize its influence. Indeed, several feminists have framed autonomy as a set of skills to be practiced in enabling circumstances and within supportive relationships.¹⁹⁹ BIPOC trans health activists have benefitted from the lessons shared by BIPOC feminist activists in the arena of reproductive justice. The critical parallel lesson is that autonomy will not flourish without equitable living conditions, and those conditions are partly achieved through collective struggle for justice. Now returning to the question of how queer and trans people of colour navigate between autonomy and agency through self-awareness practices and performance that critique culture, I will look at the theory of disidentification.

Disidentification Theory

I use disidentification theory as a tool to analyse the meaning of the photographic essays produced by youth in my focus groups. I needed an appropriate analytical tool for visual data sources created by multiply marginalized youth whose autonomy is situated in a structurally vulnerable position vis à vis society. As Lowe says, "Aesthetic representation is always...a

¹⁹⁹ Meyers 1989, *supra* note 167 at 76, 250–251; Shauna Van Praagh, "Adolescence, autonomy and Harry Potter: the child as decision-maker" (2005) 1:4 Int J Law Context 335; Paré, *supra* note 107.

debate about political representation.”²⁰⁰ In *Disidentification*, performance studies scholar José Esteban Muñoz presented: a strategy, a hermeneutic and a cultural product acted out by queer people of colour in public.²⁰¹ Identification is a way of relating to one’s social and political environments.²⁰² To disidentify is not just to simply counter identify which is to see oneself as the opposite or to totally reject available identity labels. To disidentify is to manipulate and evoke themes without announcing oneself or one’s representation in the dominant culture’s images and narratives.²⁰³ One example is flagging, whereby one dons a suit but has an undercut hairstyle to mark one’s queerness. Muñoz defines disidentification as “descriptive of the survival strategies the minority subject practices in order to negotiate a phobic majoritarian public sphere that continuously elides or punishes the existence of subjects who do not conform to the phantasm of normative citizenship.”²⁰⁴ Muñoz argues that queer people of colour are marginalized and culturally invisible. This experience of invisibility and/or negative representation increases the importance and the burden of visual representation.²⁰⁵ Margo Machida says this about the importance of visual art by immigrant people of colour in the West, “The symbolic assertion of presence through strategic acts of visual representations...provide a previously neglected people with a powerful claim to place in a society where their images are not the norm.”²⁰⁶ Therefore as performers, trans racialized youth disidentify in order to

²⁰⁰ Lisa Lowe, *Immigrant acts: on Asian American cultural politics* (Durham: Duke University Press, 1996) at 4; see also bell hooks, *Art on my mind: visual politics* (New York: New Press, 1995).

²⁰¹ Muñoz, *supra* note 134 at 4, 11, 12.

²⁰² *Ibid* at 7.

²⁰³ *Ibid* at 11–12.

²⁰⁴ Muñoz, *supra* note 134 at 4–5.

²⁰⁵ hooks 1995, *supra* note 201; Muñoz, *supra* note 134 at 8; Alix Holtby et al, “To be seen or not to be seen: photovoice, queer and trans youth, and the dilemma of representation” (2015) 13:4 *Action Res* 317 at 318–319.

²⁰⁶ Margo Machida, *Unsettled visions: contemporary Asian American artists and the social imaginary, objects/histories* (Durham: Duke University Press, 2008) at 6.

“[scramble] and [reconstruct] the encoded message of a cultural text in a fashion that both exposes the encoded message’s universalizing and exclusionary machinations and recircuits its workings to account for, include, and empower minority identities and identifications.”²⁰⁷

In addition to being a hermeneutic strategy, Muñoz also describes disidentification as a process of cultural production.²⁰⁸ He sees disidentifying cultural production occurring between the reception of dominant cultural codes and the opposition to them.²⁰⁹ Muñoz is careful to acknowledge that as a counter-hegemonic strategy, disidentification is imperfect because of its indirectness and ambivalence towards oppressive and dominant structures.²¹⁰ Part of why disidentification is so accurate as a theory however, is because it can hold the tension between being inextricably part of late-stage capitalist society and resisting being defined by those who hold power in our society.²¹¹ Judith Butler described agency as making voluntary decisions based on circumstances even where they are embedded in subordination. Butler writes, “Where conditions of subordination make possible the assumption of power, the power assumed remains tied to those conditions but in an ambivalent way.”²¹²

Trans racialized youth can be and may have to be ambivalent about using pathologizing diagnostic terms in institutional settings. They may have to be ambivalent about norms to take up or discard in order to obtain gender and life supportive services. There are downsides to this.

²⁰⁷ Muñoz, *supra* note 134 at 31.

²⁰⁸ *Ibid* at 25.

²⁰⁹ *Ibid* at 26 where Muñoz references Stuart Hall’s theory of broadcast media messaging through the use of normative codes, described in Hall’s essay “Encoding/Decoding”. Muñoz takes up the idea of receptive opposition as a method of interacting with media products.

²¹⁰ *Ibid* at 71.

²¹¹ Michelle O’Brien, “Tracing this Body: Transsexuality, Pharmaceuticals, and Capitalism” in Stryker & Aizura, *supra* note 14, Judith Butler, *The psychic life of power: theories in subjection* (Stanford, Calif: Stanford University Press, 1997) at 56 [Butler 1997a].

²¹² Butler 1997a at 13.

Once you identify with something you lose other possibilities in an attempt for stability. This is what Butler calls the “cost of identification”.²¹³ Butler in her theorizing of drag queen culture also suggests that drag queens engage with unstable axes of power²¹⁴ in terms of gender and sexuality. Butler observes that drag queens perform tropes of femininity and oppression to mean something different from white straight able-bodied cis femininity – something that might be subversive. I would also add that drag interprets race, class and many other identities. For example, the Toronto queer drag performer Patrick Salvani uses the horror genre to create anti-racist revenge performances out of the histories and experiences of Filipinx people in the caregiver role who flip the script on their sponsors in kitchen and cooking based scenarios about servitude gone amok.²¹⁵ This notion of ambivalence – which I use to describe the act of adopting or amplifying stereotypes in an attempt to challenge dominant ideologies about race, gender and sexuality from within dominant culture – is a core element of disidentification. Disidentification is necessary for survival and it offers critiques, just not in predictable forms.²¹⁶

The significance I take from Muñoz’s theory in application to my participants’ works is their potential to re-make “real” worlds using their own values and references. The practice of worldmaking establishes critiques and even suggests futures for “minoritarian” youth. As Muñoz puts it, “Worldmaking produces creative perspectives by slicing into the facade of the ‘real’ that is the majoritarian public sphere.”²¹⁷ The components of the majority public sphere become the

²¹³ Judith Butler, *Bodies that matter: on the discursive limits of “sex”* (New York: Routledge, 1993). Judith Butler 1993 at 126 [Butler 1993].

²¹⁴ Judith Butler, *Gender trouble: feminism and the subversion of identity* (New York, NY: Routledge, 1990) at 17 [Butler 1990].

²¹⁵ Patrick Salvani, “Dragging Filipinx: A Series of Performative Vignettes”, in Robert Diaz, Marissa Largo and Fritz Pinto eds, *Diasporic Intimacies: Queer Filipino and Canadian Imaginaries* (Evanston, Illinois: Northwestern University Press, 2018) 198.

²¹⁶ Muñoz *supra* note 134 at 166-167.

²¹⁷ *Ibid* at 196.

source materials for queer world reconstruction. So, while the state through its actors must perform state power, marginalized or minoritarian artists build power through performance. Muñoz emphasizes *the doing* as the important part of the disidentification method, not so much *the being* or *knowing*.²¹⁸ One example of doing disidentification is the youth of colour drag performance culture in Toronto centered around the annual Asian Arts Freedom School Drag Musical. The Drag Musical uses drag as a vehicle for intersectional critique by queer and trans racialized youth of mainstream gay normativity through comedy and musicality.²¹⁹ The Drag Musical performers take on very familiar pop culture themes like “Christmas Holidays”, “Requiem for a Dream” and “Eat Pray Love” and turn them into comedic and nuanced commentary on modern life.²²⁰

Another way of attacking the “real” comes through Muñoz’s concept of “tactical misrecognition”.²²¹ Misrecognition entails, strategically, and often humorously, taking a position as one’s own and that one is *not* seen to own.²²² This concept is related to the key disidentifying act of *connoting* identity rather than *demonstrating* it through recognizable symbols. Those who disidentify eschew familiar and acceptable forms of racial, ethnic, and gender representation. They also avoid the familiar economy of resistance through positive or sanctioned multicultural representations of their race or gender.²²³ They negotiate something else. Here is where intersectionality is so key for queer people of colour and for trans people of colour as well: since they exist in multiple identity positions, they focus on related differences within identities not

²¹⁸ *Ibid* at 200.

²¹⁹ Email correspondence with Drag Musical Director Patrick Salvani March 4th, 2018.

²²⁰ <http://marvellousgrounds.com/blog/the-drag-musical/>

²²¹ Muñoz, *supra* note 134 at 165, 167–169.

²²² On feminist use of misrecognition see Butler 1993 *supra* note 214 at 219.

²²³ Muñoz, *supra* note 134 at 165 and 167–169.

just difference between identities. To return to tactical misrecognition, you might refuse to see yourself in something coded as emblematic of your identity box, or you might insist on reading yourself into materials not meant for your subject position. The works of the Femme Fatales Burlesque Company offer several local examples of disidentification and tactical misrecognition. The Company produces several themed shows each year featuring primarily racialized and Black performers of a variety of body types, abilities, sexual orientations and genders.²²⁴ In a trilogy titled Triple Goddess, “Virgin, Mother, Crone” performers complicated and disrupted these universal female life stages. Furthermore, the poster cover girl for the Virgin show featured a dark-skinned Black woman with floral attire and an innocent look. This is a role that dark Black women are not typically allowed to perform. The cover girl was neither sexualized, lightened nor mainstreamed. For the Crone section of the trilogy, Femme Fatales performer Betsy Spoon, appears completely naked with rolling carry-on suitcase filled with Dollar Store plastic bags lip-synching to the song Bag Lady, as she returned to herself by giving away her baggage. A third example appears in the poster for the Church-themed show where the concept of worship was twisted by cover girl Axl Blows pictured as a stripper against a stripper pole as an icon of holiness. Overall, I apply disidentification theory to trans racialized youth participants’ expressions to understand how they foster autonomy skills and deploy agency in the context of their health. Next, we look at how intersectional identities, individual lived experience, collective resistance and embodied gender all intertwine in transgender theory, the theoretical gender foundation for this thesis.

²²⁴ Phone Conversation with Dainty Smith of Femme Fatales, March 9th, 2018.

Transgender Theory

Over three decades of academic and non-academic theorizing about the nature of gender, sexuality, sexual orientation and race have resulted in much polarizing debate.²²⁵ Despite the difficulty of committing to a position, for a research project about trans racialized youth, I needed a gender theory nuanced and robust enough to hold life experiences, embodiment, intersectional identities and collective political associations. Furthermore, my methodology explained in detail in Chapter 3, required that I integrate a theory of gender into my qualitative methods. Ultimately, I chose transgender theory, developed by social work graduate students, to use as a pluralist container for my research. To set the context for transgender theory, I briefly summarize previous debates on the nature of gender from feminist and queer theory.

Through the 1970s and 1980s Western essentialist theories of gender locked our gender identities and expressions onto our biological selves.²²⁶ Genital anatomy at birth defined one's sex with gender following from the natal sexed body.²²⁷ Only two oppositely sexed bodies were accepted as normal.²²⁸ For some time science affirmed this view calling it "sexual

²²⁵ Emi Koyama, "Whose Feminism is it Anyway? The Unspoken Racism of the Trans Inclusion Debate" in Susan Stryker & Stephen Whittle, eds, *Mutilating Gender* (New York: Routledge, 2006) at 704; Pyne 2016, *supra* note 47; Talia Mae Bettcher, "Trapped in the Wrong Theory: Rethinking Trans Oppression and Resistance" (2014) 39:2 *Signs* 383.

²²⁶ Mary Daly, *Gyn/ecology: the metaethics of radical feminism* (Boston: Beacon Press, 1978); Janice G Raymond, *The transsexual empire: the making of the she-male* (Boston: Beacon Press, 1979); Julia Kristeva, *The Kristeva reader*, Toril Moi, ed. (Oxford: Basil Blackwell, 1986); Germaine Greer, *The whole woman* (New York, NY: Doubleday, 1999); For critiques of gender essentialism see Bernice Louise Hausman, *Changing sex: transsexualism, technology, and the idea of gender* (Durham, N.C: Duke University Press, 1995).

²²⁷ J. Green, 2004 *Becoming a Visible Man*. In Chapter 4 I connect this belief to the legal category of gender/sex using Sharpe's term "the (bio)logic" in Sharpe 2002 *supra* note 51.

²²⁸ Harold Garfinkel, *Studies in ethnomethodology*. -- (Englewood Cliffs, N.J: Prentice-Hall, 1967).

dimorphism”.²²⁹ This meant that if a baby was born intersexed then its body was surgically “converted” to anatomically match one of the binary sexes. Some feminists agreed with this binary biology because it allowed them to claim that cissexual women possessed unique powers and qualities.²³⁰ Masculinity was associated with the autonomy-enhancing behaviors of men and femininity was either romanticized or denigrated. Through the 90s feminist and queer theorists challenged the essentialism²³¹ of sex determining gender, and gender as a stable ideology and an epistemology²³² that predicted everything about one’s life.²³³ Instead of being “natural”, gender could be theorized as socially constructed. If gender was socially constructed and a product of hegemonic discourses, then it could be deconstructed and disembodied. In academic feminist critiques of biological essentialism, heterosexuality and reproductive roles were challenged, yet the universal category of “woman” was tacitly understood to be cisgendered, able-bodied and white and often middle class. Anti-racist women of colour feminists and lesbian feminists critiqued this universalized “woman”.²³⁴ Another strand of feminism also deployed biological determinism to reject gender identity and in effect reject or block transsexual women

²²⁹ Science has now debunked the theory of sexual dimorphism although surgeries to “fix” intersex babies still occur see Julie A Greenberg, “Defining Male and Female: Intersexuality and the Collision between Law and Biology Symposium--Therapeutic Jurisprudence” (1999) 41 Ariz Law Rev 265.

²³⁰ For example, see Cixous 1986, Irigaray 1991, Kristeva 1986.

²³¹ I use Grillo’s definition of essentialism: An essentialist outlook assumes that the experience of being a member of the group under discussion is a stable one, one with a clear meaning, a meaning constant through time, space and different historical, socio political, and personal contexts Trina Grillo, “Anti-Essentialism and Intersectionality: Tools to Dismantle the Master’s House” in Elizabeth Hackett & Sally Anne Haslanger, eds, *Theor Fem Read* (New York: Oxford University Press, 2006) 30 at 32.

²³² Hausman, *supra* note 227.

²³³ Butler 1993, *supra* note 214; Kate Bornstein, *Gender outlaw: on men, women, and the rest of us* (New York: Routledge, 1994); Riki Anne Wilchins, *Read my lips: sexual subversion and the end of gender* (Ithaca, NY: Firebrand Books, 1997).

²³⁴ Moraga & Anzaldúa, *supra* note 136; Hull et al, *supra* note 136; Audre Lorde, “Age, Race, Class and Sex: Women Redefining Difference” in *Sister Outsider: Essays Speeches*, Crossing Press feminist series (Trumansburg, NY: Crossing Press, 1984) 114; bell hooks, *Feminist theory: from margin to center* (Boston, MA: South End Press, 1984).

and non-binary people from women's spaces and women's movements, while still attempting to resist their version of an oppressive patriarchal construction of gender.²³⁵

Nagoshi and Brzuzy's Transgender theory considers that some feminists and queer theorists separated gender from sex while many trans people experience the two as a whole.²³⁶

Transfeminist Kate Bornstein argued that sex was made up of more than genital and reproductive factors and preferred to refer to "sex" instead as "biological gender".²³⁷ Nagoshi and Brzuzy also attend to the problems with disembodiment of gender. For example, if gender is merely a series of performative gestures and social artifice²³⁸, then the transsexual need to modify one's body to match one's internal sense of gender can be framed as wallowing in old fashioned biological determinism. This tendency to elide the specific medical needs of transsexuals and portray them as backwards or unfeminist has been heightened in queer and transgender theorizing.²³⁹ In their Transgender Theory, Nagoshi and Brzuzy however incorporate a sense of gender that is indeed felt and lived through the body.²⁴⁰

While one of the hallmarks of the poststructuralist brand of queer theory is fluidity of categories and the absence of a true self, this has been critiqued by trans and queer scholars of colour as a privileged position and a dangerous analytical method.²⁴¹ If there is no central self how do we understand the uniqueness of individual lived experience? On the other hand, there are difficult implications of deconstructing all social identities, for collective social movements

²³⁵ Koyama, *supra* note 226.

²³⁶ Nagoshi and Brzuzy *supra* note 135 at 434.

²³⁷ Kate Bornstein, *supra* note 234.

²³⁸ Butler 1990, *supra* note 215 at 24-25.

²³⁹ Riki Lane, "Trans as Bodily Becoming: Rethinking the Biological as Diversity, Not Dichotomy" (2009) 24:3 *Hypatia* 136.

²⁴⁰ Nagoshi and Brzuzy *supra* note 135.

²⁴¹ Butler 1990 *supra* note 215. For critique of this position see Nagoshi and Brzuzy *supra* note 135 at 435.

and also for the formation of a cohesive sense of self for oppressed people. Identity can be the foundation for self-empowerment that can propel anti-oppression movements.²⁴² Single identity movements are indeed problematic and therefore an intersectional theory of transgenderism is necessary to recognize the leadership of racialized trans people and trans people who embody more than just transness.²⁴³

Nagoshi and Brzuzy's Transgender theory maintains a place for gender fluidity, non-binary identities and positions of masculinity and femininity. They orient themselves to incorporate the body as a social actor not just a container, the self and societal norms as shaping gender identity.²⁴⁴ They refine feminist relational theory where embodiment is considered a crucial part of self-awareness to express a dynamism between the self, the body and its lived experiences within its social environment including social norms and material conditions.²⁴⁵ Nagoshi and Brzuzy would consider this dynamism the basis for the autonomous self existing in relation to these sources.²⁴⁶ Intersectionality energizes this theory of gender because of its insistence on what we experience through our bodies and how we identify or disidentify with social constructions of our identities. Namaste, for example, asks for scholars to consider how narratives of criminalization, sex work and labour are told through the bodies of transsexual women in Quebec.²⁴⁷ Salah emphasizes Namaste's critique of the use of "citizenship" and "personhood" in Salah's comparison of Butler and Namaste.²⁴⁸ Namaste is clear that use of such

²⁴² Nagoshi and Brzuzy *supra* note 135 at 439–440.

²⁴³ *Ibid.*

²⁴⁴ *Ibid* at 435; Kapusta, *supra* note 162 at 151.

²⁴⁵ Shotwell and Sangrey *supra* note 174.

²⁴⁶ Nagoshi and Brzuzy *supra* note 135 at 437.

²⁴⁷ Namaste 2009 *supra* note 49.

²⁴⁸ Salah, *supra* note 47 at xi and see Namaste 2011 *supra* note 10.

terms to ground trans “liberation” entrenches trans struggles in imperialist and capitalist modes of production and understanding. Similarly Nael Bhanji critiques the frequent use of the symbols of “home” and “border crossing” within transsexual narratives asking what transsexual citizen gets to speak for transsexual subjectivity in finding “home”.²⁴⁹ Bhanji points to the racism and colonialism implicit in the transsexual search for home which cannot be accessed by racialized and/or trans immigrants or refugees who are part of a diaspora²⁵⁰ or I would add, a dislocated Indigenous person. Instead, in creating transsexual and transgender narratives he asks for a greater attempt to disidentify with “home” as a metaphor for the body, and “journey” as a metaphor for transitioning. These are but a few of the trans of colour critiques of academic trans studies, feminist and queer theory and mainstream trans writings building on the discussion in Chapter 1.

Conclusion

This chapter provided the conceptual groundwork for the analysis of pluralist sources of law and original data from trans racialized youth in the following chapters. I described the theoretical concepts of intersectionality, structural vulnerability, relational autonomy, and the analytical tools of disidentification and transgender theory. I developed my own list of autonomy-enhancing factors to apply to my analysis in Chapters 4 and 5. The factors are: information sharing, access to justice, transparency of power in relationships, personal responsibility, self-awareness, and interdependence.

²⁴⁹ Bhanji, *supra* note 49 at 1, 7–8.

²⁵⁰ *Ibid* at 4,9.

These containers and tools allow us to better understand the ways in which the experiences of trans racialized youth and their visual stories engage with the hegemonic narratives about health, race, gender, body and self that are embedded in legal and medical culture and discourses

Chapter 3: Methods & Methodology

Throughout my preliminary community consultations and literature review, I developed and refined my choice of data sources and collection and analysis methods. I decided to use traditional primary legal sources including legislation, Hansard debates, policy documents and jurisprudence, with academic literature as a secondary source. I knew I had to get at trans racialized youth's experiences of health care decision making and use inductive reasoning to draw conclusions. Therefore, I decided on a focus group Photovoice method to learn from group discussions and obtain visual data.²⁵¹

In Part I of this chapter I explain the methods of analysis I used on the legal source documents I collected, based on a blended internal and external method articulated by Schwartz.²⁵² In Part II, I describe and problematize my two participatory qualitative fieldwork methods: feminist participatory research (FPR) and visual arts-based methods, specifically Photovoice. I consider the ethical considerations arising from using photography-based methods with a structurally vulnerable population by applying relational and situated visual ethics. I describe why I chose thematic network analysis as a focus group data analysis method and conclude with observations.

²⁵¹ John W Creswell, *Qualitative inquiry & research design: choosing among five approaches*, 2nd ed. ed (Thousand Oaks: Sage Publications, 2007) at 133.

²⁵² Richard L. Schwartz 'Internal and External Methods in the Study of Law', *Law and Philosophy*, Vol. 11 No. 3 (1992), 179-199.

Guiding Concepts

Underpinning my inquiry into the decision-making autonomy of trans racialized youth are two concepts: legal pluralism and “laws as tactics”. Below, I describe how these two concepts shape my legal research before turning to my analytical method.²⁵³

Critical Legal Pluralism

Contemporary legal pluralism explains law as a phenomenon fed by many sources beyond the formal and experienced in different ways beyond statutes and courtrooms.²⁵⁴ I hoped to capture how trans racialized youth experience decision-making in health consent law and I hypothesized that as a group they are legally constructed through the regulation of gender, age and race. I saw this regulation occurring in several places: the clinic, the emergency room, the courtroom, in the Legislative Assembly and in community spaces. Applying a legal pluralistic approach to my research question allowed me to mine four different categories of information for legal rules and norms.²⁵⁵

Laws as Tactics

²⁵³ *Ibid.*

²⁵⁴ Martha-Marie Kleinhans & Roderick A Macdonald, “What Is a Critical Legal Pluralism Le Pluralisme Juridique/Legal Pluralism” (1997) 12 Can J Law Soc 25 at 31–2.

²⁵⁵ *Ibid* at 32.

Singh's FPAR checklist for researchers (Fig. 1) asks us to clearly articulate a theory of gender and show how it impacts our methodology. Spade's notion of "Laws as Tactics" helped me connect my gender theory to my method of legal analysis.²⁵⁶ Spade draws from Foucault and Butler to push scholarship on gender's interaction with the law into the consequences of discursive subjectivity formation through the multiple elements that make up "the law".²⁵⁷ Spade references Foucault's writings on the disciplinary and norm-producing function of law and Butler's writings on the performative nature of gender and its social construction, as discussed in Chapter 2²⁵⁸ describing laws as tactics deployed to achieve the state's population level aims.²⁵⁹ In a pluralist fashion, Spade also decentralizes "the law" noting the spread of law's action beyond what statutes *say* and into what elements of the law *do*, in the pluralist sense, to trans people.²⁶⁰ As I demonstrated in Chapter 1, certain subjectivities benefit from norms produced by law and medicine, and others are punished when laws tactically refuse to recognize them.²⁶¹ Through "laws as tactics" Spade considers how trans people interpret laws locally to achieve their desired ends and also to resist gender essentialism and the imposition of the gender binary.²⁶² I borrow from Spade's approach to draw out the disciplinary functions of my four sources.

²⁵⁶ Spade 2012 *supra* note 199.

²⁵⁷ Spade 2012, *supra* note 199 at 41.

²⁵⁸ Butler 1990 *supra* note 215 at 33, 114, 232; Butler 1997a, *supra* note 212; Michel Foucault, Society must be defended: lectures at the Collège de France, 1975-76.

²⁵⁹ Spade 2012, *supra* note 199 at 54; Graham Burchell et al, The Foucault effect: studies in governmentality: with two lectures by and an interview with Michel Foucault (Chicago, IL: University of Chicago Press, 1991) at 95.

²⁶⁰ Spade 2012, *supra* note 199 at 68.

²⁶¹ *Ibid* at 44-45.

²⁶² *Ibid* at 44; Butler 1990, *supra* note 215 at 13.

As theoretical tools used in tandem, critical legal pluralism and laws as tactics helped me select and analyse my sources. These concepts took me to an inquiry of not just how laws and subjects interact but how subjects might interpret, deploy and/or resist legal norms.

Part I Legal Sources and Methods

I selected four types of legal knowledge to answer my research question: how do trans racialized youth experience autonomous and or agentic decision making in health care. Statutory law is the first type of legal knowledge. As I demonstrated in the first two chapters, statutory law currently defines sex as a legal category and confines the subjectivity of trans people administratively limiting their life outcomes. I probe deeper into formal law by reading legislators' intentions and opinions about my chosen statutes in Hansard debates of my selected statutes concerning decision making in health, age and gender identity. Decisions of courts and tribunals constituted the second form of knowledge. However, trans racialized youth are non-existent in reported court decisions. Trans youth are the subjects of a small number of family law cases and administrative tribunal decisions. In contrast, the case law on mature minors and health care decision-making is rich. Between the two bodies of jurisprudence I can demonstrate the opinions of judges and decision makers regarding gender identity, biology, legal capacity and age-based decision-making autonomy. The third form of legal knowledge is health care providers' normative clinical and diagnostic practices, accessed through their authoritative texts. Fourthly, the way that health care providers apply the common law and statutes is accessed from published studies of health care providers and from the experiences of focus group participants.

Kleinhan and MacDonald's critical legal pluralism supported my choice to seek out the daily experiences of trans racialized youth as law-creators who hold law within themselves.²⁶³

Through a Photovoice project, Trans racialized youth produced visual and textual narratives that gave me an idea of what local law and autonomy/agency practices were, even if practices differed from what the statute prescribed.²⁶⁴ This phenomenology of trans racialized youth autonomy is shared in Chapter 5 through my fieldwork findings and analysis.

Internal and External Analytical Method

Webber notes two tendencies in legal pluralism, namely: deference to law in its social context and the production of norms through the active choice of legal outcomes from a selection of options.²⁶⁵ These tendencies will support my application of Schwartz's interpretive methods, to my analysis of law and policy impacting the autonomy of trans racialized youth in health care.

Unlike the internal analytical method, which seeks the intrinsic cumulative principles or logic of law, external forms of legal analysis seek to get at truth and evaluate process. The external method is not limited by acceptance of classic texts as authoritative sources or by the hegemony of professional opinions²⁶⁶ and thus the external method can apply knowledge and methods from other scholarly fields. Like other legal scholars, I use a combination of internal and external analytical methods, as demonstrated in the four main sources I used.²⁶⁷

²⁶³ Kleinhans & Macdonald, *supra* note 255 at 38–40.

²⁶⁴ Jeremy Webber, "Legal Pluralism and Human Agency" (2006) 44 Osgoode Hall LJ 167 at 171; *ibid* at 38.

²⁶⁵ *Ibid* at 169.

²⁶⁷ *Ibid* at 194.

²⁶⁷ *Ibid* at 194.

Sources of Legal Norms

Ontario statutes dealing with health care consent were most clearly connected to my research question. The primary statute for decision-making in health care is the current *Health Care Consent Act* 1996 (*HCCA*).²⁶⁸ For historical background, I considered its antecedent the *Consent to Treatment Act* 1992 (CTA), and the now repealed *Advocacy Act* 1992.²⁶⁹ I read these three statutes together to see how in the last 25 years legislators dealt with freedoms and protections for minors and other groups like disabled people who were perceived to be vulnerable in health care. Regulation 552 of the *Health Insurance Act* 1990 (detailing provincial health insurance coverage) was another key source because most youth access health care but especially gender-affirming treatments through OHIP.

A practitioner's guide was helpful in understanding the practical uses and implications of the consent, capacity, substitute decision maker and liability provisions.²⁷⁰ I used the Law Commission of Ontario's Final Report on Legal Capacity and Decision-making for wider historical policy development information.²⁷¹ Hansard debates over amendments to health care statutes between 1990-1996 covered questions including mature minors and the appropriate age for consent to treatment and included the depositions of parents, doctors and others. The *Affirming Sexual Orientation and Gender Identity Act* 2015 (ASOGIA) banned conversion therapy on minors. Debates during 2015 about the private member's bill that became ASOGIA

²⁶⁸ *HCCA supra* note 11.

²⁶⁹ *Consent to Treatment Act*, SO 1992, repealed on March 29, 1996 c. 2, s. 2 (2); [CTA]; *Advocacy Act*, 1992, SO 1992, c. 26 [AA].

²⁷⁰ D'arcy Hiltz & Anita Szigeti, *A Guide to Consent and Capacity Law in Ontario*, 2017th ed (Toronto: Lexis Nexis Canada, 2017).

²⁷¹ Law Commission of Ontario, *Legal Capacity, Decision-making and Guardianship*, Final Report (Law Commission of Ontario, 2017) [LCO 2017]. One major limitation of the Report was that it does not address issues for minors or youth at all, rather focusing on elderly and mentally disabled or incompetent people.

involved many trans community members, activists and scholars. I also read the provisions of the *Criminal Code* that ban medically assisted death for minors. Reading both the debates and the Statutes helped to illustrate both what evidence had been considered and why the legislature made certain choices. Tracking the opinions and reasoning of judges with respect to trans racialized youth proved to be much more elusive.

Jurisprudence

I had hoped to find trans youth litigating their rights to gender-affirming treatments but this proved very difficult. Where I did find cases, the race/ethnicity of the youths were not mentioned at all. I also read one custody case from British Columbia involving the treatment of a racialized non-binary child because I had access to the child's lawyer who offered further insight into how legal actors engage with the autonomy of trans minors.

Authoritative Texts

I returned to external methods by considering policy documents that impact the way health care is delivered, accessed, or denied to trans racialized youth, choosing three policy documents issued by health care providers and researchers from an international clinical association, a provincial professional association and a local community health centre. Firstly, in order to explore what rules the Ontario government requires health care providers to follow if providing transition-related and gender affirming care to trans youth I examined the most current version of The Standards of Care issued by the World Professional Association for Transgender Health

(WPATH SoC).²⁷² The Ministry of Health and Long-Term Care adopted these standards to regulate the public subsidy of gender-affirming treatments.²⁷³ The SoC affirm the psychiatric diagnostic criteria for gender dysphoria from the *Diagnostic and Statistical Manual Version V* and so they provided a view into narratives for transness generated by medical and government institutions relevant to my research question.²⁷⁴ For contrast, I turned to the Sherbourne Health Centre's *Guidelines and Protocols for Hormone Therapy and Primary Care for Trans Clients* (2015) for contrast with the international clinical standards. The SHC is notable because it is a family physician and nurse-based health centre with close ties to Toronto's queer and trans communities. Some trans racialized youth go to the Sherbourne Health Centre for primary health care and psychosocial programming. Finally, I read the College of Physicians and Surgeons of Ontario's official policy statement on Consent to Treatment updated in 2015.²⁷⁵ The *HCCA* leaves several key processes to be determined by regulated health care professionals' colleges and this document was intended to fill a statutory gap. I compared this document and the accompanying frequently asked questions section with opinions about consent practices and autonomy expressed by the three Ontario doctors I consulted in 2016-2017. Secondary material by psychiatrists and pediatricians about how to apply the *HCCA* with youth patients was helpful in fleshing out the physicians' identification of challenges and solutions, although none of these sources dealt specifically with trans youth or racialized youth.²⁷⁶

²⁷² World Professional Association for Transgender Health, *Standards of Care for the Health of Transgender, and Gender Nonconforming People Version 7* (World Professional Association for Transgender Health, 2011).

²⁷³ Ministry of Health and Long-Term Care Government of Ontario, "Sex Reassignment Surgery", online: <<http://www.health.gov.on.ca/en/pro/programs/srs/>>.

²⁷⁴ American Psychiatric Association & American Psychiatric Association: *DSM-5* Task Force, *supra* note 3.

²⁷⁵ College of Physicians and Surgeons, Policy Statement #3-15 Consent-To-Treatment (College of Physicians and Surgeons of Ontario, 2015) [CPSO 3-15].

²⁷⁶ Dr Miriam Kaufman, "The Impact of the Ontario Consent to Treatment Act (Bill 109) on Adolescent Health Care" (1994) 15:2 Health Law Can 31; Rose Geist & Susan E Opler, "A Guide for Health Care Practitioners in the

Part 2 Qualitative Research

Methodology

Paradigms and Feminist Participatory Research

The feminist participatory research method I employed in the second component of my work is embedded in a transformative paradigm. Mertens described the transformative paradigm as an improvement on the emancipatory paradigm because of its emphasis on the leadership of marginalized research populations rather than their experience as objects emancipated by researchers.²⁷⁷

FPR developed out of the body of work exists critiquing well-intentioned but damaging community-academic partnerships. For as Koggel says, there is exploitation implicit in research and simply *focusing* on marginalized and oppressed people does not ensure that equity is achieved.²⁷⁸ To avoid the methodological pitfalls of traditional CBPR, I adapted methods of

Assessment of Young People's Capacity to Consent to Treatment" (2010) 49:9 Clin Pediatr (Phila) 834; Rose Geist, "The Capacity to Consent to Treatment in Youth" (2015) 35:3 Health Law Can 79.

²⁷⁷ Donna M Mertens, *Transformative research and evaluation* (New York: Guilford Press, 2009) at 48-49.²⁷⁸ An excellent overview of these critiques is found in Adrian Guta, Carol Strike, Sarah Flicker, Stuart J. Murray, Ross Upshur, and Ted Myers. "Governing through Community-Based Research: Lessons from the Canadian HIV Research Sector." *Social Science & Medicine* 123 (December 2014): 250–61.

<https://doi.org/10.1016/j.socscimed.2014.07.028>; Christine M Koggel, "A Relational Approach to Equality: New Developments and Applications" in Jennifer Llewellyn & Jocelyn Downie, eds, *Being Relational: Reflections on Relational Theory and Health Law* (Vancouver, BC: University of British Columbia Press, 2011).

²⁷⁸ An excellent overview of these critiques is found in Adrian Guta, Carol Strike, Sarah Flicker, Stuart J. Murray, Ross Upshur, and Ted Myers. "Governing through Community-Based Research: Lessons from the Canadian HIV Research Sector." *Social Science & Medicine* 123 (December 2014): 250–61.

<https://doi.org/10.1016/j.socscimed.2014.07.028>; Christine M Koggel, "A Relational Approach to Equality: New Developments and Applications" in Jennifer Llewellyn & Jocelyn Downie, eds, *Being Relational: Reflections on Relational Theory and Health Law* (Vancouver, BC: University of British Columbia Press, 2011).

researcher Singh who added a feminist anti-oppression praxis to CBPR methods in her research with trans youth to conduct feminist participatory action research (FPAR).²⁷⁹ Her use of FPAR methods has made spaces for trans racialized youth to articulate barriers, agentic strategies and long-term autonomy producing solutions.²⁸⁰ Singh's studies rigorously consider the ethical implications of cis adults researching with trans youth. Mirroring Merten's move from "emancipatory" to "transformative" paradigms for research, Singh et al. are skeptical of research that claims to empower and know trans people.²⁸¹ Singh insists that FPAR researchers must examine all of their beliefs, expectations, and desires for their research before deciding on methods and before undertaking fieldwork. To this end, I completed Singh's thirteen-point questionnaire for researchers as I prepared my research design and my ethics documentation.²⁸²

Photovoice

Photovoice is a form of participant-employed photography (PEP).²⁸³ PEP allows the participant, along with the researcher, to determine both the subject and meaning of the photograph, which is important to the power-sharing aspect of FPR.²⁸⁴ Additionally, the participant's captioning and explanation of their own photographs can also convey significant

²⁷⁹ I am not including the word "action" in my methodology because I am not attempting social action with this fieldwork, still see the work of Anneliese Singh, Kate Richmond & Theodore R Burnes, "Feminist Participatory Action Research with Transgender Communities: Fostering the Practice of Ethical and Empowering Research Designs" (2013) 14:3 International Journal of Transgenderism 93, online: <<http://dx.doi.org/10.1080/15532739.2013.818516>> [Singh et al 2013b].

²⁸⁰ Singh, 2013a *supra* note 50.

²⁸¹ Singh et al, 2014 *supra* note 50 at 219.

²⁸² Singh et al 2013 *supra* note 281 at 97, 101.

²⁸³ Heather Castleden, Theresa Garvin & Huu-ay-aht First Nation, "Modifying Photovoice for community-based participatory Indigenous research" (2008) 66:6 Soc Sci Med 1393 at 1395.

²⁸⁴ Britta Carlsson, "Depicting Experiences" (2001) 45:2 Scandinavian Journal of Educational Research 125 at 130.

socio-cultural nuances.²⁸⁵ Wang describes it as a process for participants to identify, represent and enhance their community through a specific photographic technique.²⁸⁶

Photovoice draws from two theoretical frameworks: 1) the critical popular education of Freire;²⁸⁷ and 2) the feminist theory that lived experience creates expert knowledge,²⁸⁸ infusing these theories into a community-based documentary approach to photography.²⁸⁹

In my view, the purpose of my fieldwork was not a concrete social change. I had seen from the literature and from community consultation that many social action research projects fall short on their promises of social change.²⁹⁰ Instead I would seek to encourage personal and collective reflection on autonomy experiences and practices, interpret the resulting phenomenological data and *if possible*, share policy recommendations at conferences and with legal and health care providers in Ontario. In choosing to conduct qualitative research using a phenomenological approach I was not trying to generalize from my sample to the broader population.²⁹¹ Working with 3-6 participants would allow for easier trust building, richer textual and visual results, and easier data management.²⁹²

²⁸⁵ Paulo Freire, *Pedagogy of the oppressed*, 30th anniversary ed. ed (New York: Continuum, 2000).

²⁸⁶ Paulo Freire, *Pedagogy of the oppressed*, 30th anniversary ed. ed (New York: Continuum, 2000).

²⁸⁷ Paulo Freire, *Pedagogy of the oppressed*, 30th anniversary ed. ed (New York: Continuum, 2000).

²⁸⁸ One source on feminist epistemology is Lorraine Code, *What can she know?: feminist theory and the construction of knowledge* (Ithaca, NY: Cornell University Press, 1991).

²⁸⁹ Wang, C. C., Morrel-Samuels, S., Hutchison, P. M., Bell, L., & Pestronk, R. M. (2004). Flint Photovoice: Community Building Among Youths, Adults, and Policymakers. *American Journal of Public Health*, 94(6), 911–913 at 911.

²⁹⁰ Sarah Switzer, “What’s in an Image?: Towards a Critical and Interdisciplinary Reading of Participatory Visual Methods” in M Capous-Desyllas & K Morgaine, eds, *Creat Soc Change Creat Anti-Oppressive Arts-Based Res Methodol* (Switzerland: Palgrave Macmillan, 2018) 189 at 200; Adrian Guta et al, “Governing through community-based research: Lessons from the Canadian HIV research sector” (2014) 123 *Soc Sci Med* 250 at 257.

²⁹¹ Jonathan A. Smith, Michael Larkin & Paul Flowers, *Interpretative phenomenological analysis: theory, method and research* (Los Angeles: SAGE, 2009) at 51–52.

²⁹² *Ibid* at 52; Creswell, *supra* note 252.

The Photovoice focus group method was in keeping with the gender theory I articulated in Chapter 2 that combined embodiment, social construction, performance and intersectionality; a theory I contemplated through Singh's checklist for research methodology.²⁹³ Photovoice methods allow participants to express abstract relational concepts more than interviews, offer participants time for creative reflection and create the possibility that their images could capture nuanced experiences, feelings and meanings.²⁹⁴ Still, Singh's checklist required further reflection.

Representation, Truth and the Desire for Stories

All colonized and subjugated people who, by way of resistance, create an oppositional subculture within the framework of domination recognize that the field of representation (how we see ourselves, how others see us) is a site of ongoing struggle. (bell hooks, 2016, p. 57)

When carefully incorporated into legal research, first person narratives add direct relevance and encouraged accountability to the group being researched.²⁹⁵ The danger in elevating first person narratives to the truth comes from some of the power dynamics embedded in the research method. Influences affecting participant storytelling include: the desire to please those in power, the confines of discursive spaces for trans people, youth, and BIPOC, and the pressure of the perceived expectations of researchers.²⁹⁶ I will show in Chapter 5 how trans people could

²⁹³ Singh et al 2013b, *supra* note 281 at 97 fig .1; JL Nagoshi, CT Nagoshi & S Brzuzy, *Gender and Sexual Identity: Transcending Feminist and Queer Theory* (New York: Springer Science + Business Media, 2013).

²⁹⁴ Susan Finley, "Art-Based Inquiry: Performing Revolutionary Pedagogy" in Norman K Denzin & Yvonna S Lincoln, eds, *Handbook of qualitative research*, 2nd ed. ed (Thousand Oaks, Calif: Sage Publications, 2000) 681 at 684 see also Carlsson, *supra* note 285 at 131.

²⁹⁵ Patricia Monture-Angus, "Standing against Canadian Law: Naming Omissions of Race, Culture and Gender" (1998) 2 Yearb N Z Jurisprud 7 at 19.²⁹⁶ *Ibid.*

²⁹⁶ *Ibid.*

become barely recognizable to themselves in their narrative attempts to access treatments and services and this could also occur in research through participatory visual methods.

One example is found in Charania's account of listener expectations of "coming out" stories in anti-homophobia education.²⁹⁷ She describes the pressure to tell a linear coming out narrative that ended in a "complete" gay subject, without contradictions and unanswered questions.

Charania describes how students required clear indications of "wholeness" and "arrival" in her stories of becoming as a working-class Muslim.²⁹⁸ In their Photovoice project with queer and trans youth Holtby et al. describe how queer and trans youth struggle with the complexities of how they want to be seen as marginalized and historically misrepresented people and their fear that their experiences would be taken by cisgender viewers as representative of all queer and trans youth.²⁹⁹

Barriers to self-disclosure can come from within and without LGBTQ communities, for example biphobia, transphobia and racism were named by Holtby et al.'s participants as examples of oppressions replicated within LGBTQ communities.³⁰⁰ Wilson and Flicker's transactional sex Photovoice and digital storytelling project illustrated how structurally vulnerable people might recreate stereotypes, or affirm attitudes they think researchers want to hear, or that they feel are innocuous, while not revealing their true values and behaviours.³⁰¹ In their photographs, the young Black women did not self-disclose their own use of transactional

²⁹⁷ GR Charania, "Regulated narratives in anti-homophobia education: complications in coming out stories." (2005) 24:2-3 *Can Woman Stud* 31 at 33-4.

²⁹⁸ *Ibid* at 34. See also the counter concept of "inviting in" used by queer people of colour instead of "coming out" in Darnell L Moore, "Coming Out or Inviting In?: Part I", (12 July 2012), online: The Feminist Wire <<http://www.thefeministwire.com/2012/07/coming-out-or-inviting-in-reframing-disclosure-paradigms-part-i/>>.

²⁹⁹ Holtby et al, *supra* note 206 at 318.

³⁰⁰ *Ibid* at 322 & 323

³⁰¹ Ciann Wilson & Sarah Flicker, "Picturing Transactional Sex: Ethics, Challenges and Possibilities" in Aline Gubrium, ed, *Participatory visual and digital research in action* (2015) 73.

sex and instead shared negative views of those who did.³⁰² Relatedly, Prins writes about the resistance to being photographed or even being seen taking photographs by participants from communities that experience high levels of surveillance, rendering visual disclosure of one and one's community unsafe.³⁰³

In summary, researchers must realize that taking pictures does not mean that participants are suddenly “free” to tell the “truth” about themselves. As these research accounts demonstrate, taking and viewing photographs is situated in the histories and present conditions of local LGBTQ spaces, research contexts and in unequal age, class, racial, and gender relations. I use Photovoice to watch and analyze the image making process and to interpret the phenomenology of the resulting images and discussions about gender, race, age, agency and autonomy in health care.

Situated Visual Ethics

I applied for and received ethics approval from the York Research and Ethics Board (REB) for my fieldwork in November 2016.³⁰⁴ I also engaged with relational ethics, based on the principles of “engaged interaction, mutual respect, embodied knowledge, uncertainty and

³⁰² *Ibid* at 79.

³⁰³ Esther Prins, “Participatory photography: A tool for empowerment or surveillance?” (2010) 8:4 Action Res 426 at 429.³⁰⁴ Research Ethics Board Certificate # 2017-057; Government of Canada, Panel on Research Ethics, TCPS2 Chapter 1 Ethics Framework Core Principles <http://www.pre.ethics.gc.ca/eng/policy-politique/initiatives/tcps2-eptc2/chapter1-chapitre1/>; Eikeland calls this “condescending ethics” in Olav Eikeland, Olav. “Condescending Ethics and Action Research.” Action Research 4, no. 1 (March 2006): 37–47 at 42. Austin, Goble, & Kelecivic, 2009, at 843.

³⁰⁴ Research Ethics Board Certificate # 2017-057; Government of Canada, Panel on Research Ethics, TCPS2 Chapter 1 Ethics Framework Core Principles <http://www.pre.ethics.gc.ca/eng/policy-politique/initiatives/tcps2-eptc2/chapter1-chapitre1/>; Eikeland calls this “condescending ethics” in Olav Eikeland, Olav. “Condescending Ethics and Action Research.” Action Research 4, no. 1 (March 2006): 37–47 at 42. Austin, Goble, & Kelecivic, 2009, at 843.

vulnerability, and interdependent environment.”³⁰⁵ Reducing autonomy and choice to an individual issue of informed consent, as the REB guidelines tend to do, without regard for context will obscure larger systems of power, privilege, and oppression.³⁰⁶

As a method, Photovoice in focus groups requires attention to ethical concerns due to several factors: the creation, use and release of visual material in print and digital forms and the structurally vulnerable intimate and familiar community of my participants.³⁰⁷ In situated visual ethics (SVE) issues are addressed as they arise in the field. It encourages researchers to rethink and adjust confidentiality, anonymity expectations, informed consent processes and include SVE training for the participants and fieldwork team.³⁰⁸ In terms of the release of images made by marginalized participants, considerations must include: the reluctance to self-disclose; the appropriation of shared images by researchers or viewers; and misreadings by viewers. These are risks for marginalized participants vis a vis privileged participants and researchers. Power dynamics between the research team and the participants and also among participants will have a significant impact on how and what to share and should be subject to ongoing consent procedures.³⁰⁹

Conventional understandings of anonymity were challenged as most participants in my study chose to photograph their faces, body parts and identifying features like canes, body modifications and shoes. I did not assume that participants would want to hide their identity

³⁰⁵ Wendy Austin, Erika Goble & Julija Kelecevic, “The ethics of forensic psychiatry: moving beyond principles to a relational ethics approach” (2009) 20:6 J Forensic Psychiatry Psychol 835 at 843.

³⁰⁶ Sherwin 1998 *supra* note 157 at 36-37.

³⁰⁷ Clark, A, J Prosser, and R Wiles. “Ethical Issues in Image-Based Research.” Arts & Health 2, no. 1 (March 2010): 81–93, and John Creswell

³⁰⁸ Wilson and Flicker *supra* note 303 at 82-84.

³⁰⁹ Sherene Razack, Looking white people in the eye: gender, race, and culture in courtrooms and classrooms (Toronto: University of Toronto Press, 1998) at 36-38.

when they might seek to conduct advocacy through the subject matter of their images and by disseminating the results.³¹⁰ At the same time, I needed to be aware that participants might change their minds later and regret revealing such personal details. This tension between exposure to future harm and paternalism towards stigmatized participants required a discussion with the participants about the risk of revealing personal information, not a unilateral decision made by me to prevent them from doing so.³¹¹

Reflexivity

Because a relational ethics approach explicitly names power relations and imbalances, I knew I had to be critically aware of my own power, biases and expectations in the process and attempt to minimize restrictions or pressures on participants' decision-making autonomy.³¹² As part of the imagined audience, the fieldwork team would inevitably influence participants' actions in unanticipated ways.³¹³

The York University Human Participants Review Sub-Committee (HPRC) ethics approval process positioned me as the expert, who would determine what would be ethical and safe for my participants months in advance of meeting them.³¹⁴ Specifically, the HPRC ethics protocol form

³¹⁰ Pamela Ponc, "Balancing safety and action: Ethical protocols for photovoice research with women who have experienced violence" (2012) 4:3 189, online: <http://resolver.scholarsportal.info/resolve/17533015/v04i0003/189_bsaaepwwwhev.xml>.

³¹¹ This tension is discussed in depth in Deborah Barrett, 2004. Photo-documenting the needle exchange: Methods and ethics. *Visual Studies*, 19(2): 145–149.

³¹² Sarah Flicker et al, "Ethical Dilemma in Community-based participatory research: recommended for institutional review boards" (2007) 84:4 *J Urban Health* 478 at 481.

³¹³ Sarita Srivastava & Margot Francis, "The Problem of 'Authentic Experience': Storytelling in Anti-Racist and Anti-Homophobic Education" (2006) 32:2–3 *Crit Sociol* 275 at 285–286; Holtby et al, *supra* note 206 at 318; Esther Prins, "Participatory photography: A tool for empowerment or surveillance?" (2010) 8:4 *Action Research* 426 at 429.

³¹⁴ There is an amendment mechanism built into the institutional research ethics approval process, in order to make changes to the project after initial approval, and while the staff are very helpful the process takes weeks and is not

asks researchers to commit to recruitment language, risk mitigation, interview questions, and informed consent language without input from the participants. Yet to apply FPAR tenets to my research study and using the transformative paradigm, I preferred to act as the facilitator of ongoing information exchange and reflection.³¹⁵ In Singh's checklist for researchers, question #1 asks us to practice humility about one's knowledge and assumptions, apologize as necessary and make changes to the study based on this learning. I was not able to make changes to my study during the field work stage because any changes required approval from the REB and if I had postponed my focus groups, I would have lost participants.

Singh's checklist for researchers asked me to describe my own intersecting identities.³¹⁶ I am a queer non-youth gender non-conforming cissexual woman of colour with deep roots in the Toronto queer community. I am able-bodied. I am also a graduate student with a law degree and therefore have access to much more information about trans health care and rights than my youth participants did. The checklist also asks about researcher positionality vis a vis transgender concerns. I have had significant volunteer and professional engagement with queer and trans youth. My relationship to the youth participants was partly as a stranger researcher, however, they might have known me through LGBTQ community events. I had to consider that we knew many of the same people and we would likely continue to cross paths for years to come. Ultimately, this awareness made me feel accountable to the participants and my co-facilitator. In terms of my own preconceptions, I realised I might expect youth to have negative experiences with health care professionals due to my own negative experiences. I also might be expecting

fast enough to address the issues that come up in the field. Susan Boser, "Ethics and Power in Community-Campus Partnerships for Research." *Action Research* 4, no. 1 (March 2006): 9–21.

³¹⁵ Ponc et al., *supra* note 312 at 2010.

³¹⁶ Singh 2013b, *supra* note 281 at 97 fig 1.

trans youth to have unsupportive families. Having identified positional privileges and preconceived expectations, I could consciously bracket³¹⁷ these things to help me view the participants data as fresh and belonging to them.³¹⁸ Finally, knowledge transfer and access to research results were key considerations in Singh's checklist and I am committed to ensuring participants will have access to the completed thesis and a plain language summary of research results. Participants have been invited to all conference presentations of this research as co-presenters where possible.

³¹⁷ Clark E Moustakas, *Phenomenological research methods* (Thousand Oaks, Calif: Sage, 1994) at 96–97; Max Van Manen, *Researching lived experience: human science for an action sensitive pedagogy*, 2nd ed. ed (London, Ont: Althouse Press, 1997) at 175–176.

³¹⁸ Anneliese Singh, *supra* note 51 at 693.

Figure 1. Checklist for participatory action research (PAR) feminist researchers working with transgender communities from Anneliese Singh

- ☐ Assess one's intersecting identities (e.g., race/ethnicity, gender identity and expression, etc.) as they relate to privilege and oppression and power as a researcher
- ☐ Clearly articulate a theory on gender and determine how this theory informs methodological choices
- ☐ Reflect on researcher positionality related to transgender concerns
- ☐ Conduct a current transgender literature review informed by both peer-reviewed sources and other nonacademic sources of information (blogs, advocacy websites, novels etc)
- ☐ Provide and/or attend presentations or activities at community centers that serve transgender individuals, so that a potential PAR relationship could be initiated
- ☐ Determine community needs by working collaboratively with transgender people and communities
- ☐ Identify the opportunity for advocacy associated with the PAR study
- ☐ Work with a research team order to establish expectations and accountability related to researcher privileges, assumptions, and biases
- ☐ Use sampling practices that ensure a diverse and representative population
- ☐ Share all aspects of the research process and data with informants and communities (stake holders)—and be sure to ask for feedback and input along the way
- ☐ Practice humility about one's knowledge and assumptions, apologize as necessary, and make changes to the study based on this learning
- ☐ Understand historical oppression of transgender people and communities
- ☐ Identify how your personal liberation is connected to the liberation of the informants and participants with whom you work

Methods

Recruitment

I looked for 8-10 participants between the ages of 18 and 25 years old who identified as trans (transsexual, transgender, gender non-conforming, gender non-binary, gender fluid, genderqueer and more) at any stage of their social, legal or medical transition and who also identified as Black, Indigenous and/or people of colour. As 18+ they would not need parental consent but would be close enough to being minors to be able to remember the experience of navigating health care systems as minors and compare to their current experiences. The small number of participants meant that the group would generate comfort and trust faster, and I would be able to manage analysis of the data set by myself.

In putting together the method and the groups, I approached a number of community partners for consultation.³¹⁹ The participants were recruited through those community partners using purposive snowball sampling methods.³²⁰ For example, youth were also solicited by email and phone by youth workers from within their networks. I was available to present about the research and focus group at the 2017 Youth Sexual Health Symposium and at other youth groups, so some youth met me in person before deciding whether to participate.

³¹⁹ Planned Parenthood Toronto – Director of Community Programming and Research, Cheryl Dobinson & TEACH Program Coordinator David Udayasekaren; Supporting our Youth (Sherbourne Community Health Centre) Gender Journeys Group facilitator Kusha Dadui; LGBT Youthline Outreach Coordinator and Service Coordinator Tamar Brannigan and Naomi Martey; Griffin Centre Executive Director Tai Vo; YMCA Sprott House LGBTQ Shelter Manager Kate Miller and Case Worker Scout Bay; Gender Clinic at Sick Kids Hospital Drs. Miriam Kaufman and Joey Bonafacio.

³²⁰ Patricia Leavy, *Research Design: Quantitative, Qualitative, Mixed Methods, Arts-Based, and Community-Based Participatory Research Approaches* (New York: Guilford Press, 2017) at 78–9.

Kiley May served as focus group co-facilitator and trans community consultant.³²¹ Kiley handled the photography training section of the focus group. Kiley is a Mohawk trans feminine photographer and theatre artist. Working with Kiley fulfilled Singh's recommendations about how to determine community needs and about working with other people to provide accountability mechanisms.³²² I also thought the youth would feel more comfortable with her as another trans person, and that they would be motivated to work with her as an artist.

Participants

Eight people agreed to participate in the workshop. Two youth cancelled the night before the workshop citing work and family commitments, and two youth cancelled the morning of the workshop giving health reasons. The group expressed a variety of gender identities: trans feminine, trans, trans masculine and gender fluid. Their ethnic and racial identities were: Afro-Caribbean, biracial white Filipino, Chilean, and Pakistani. One person identified as Muslim. Class backgrounds and income levels varied, with the group including working class, working poor and middle class. In terms of ability, one youth used a cane and required several accommodations in the physical space; two youth self-identified as having anxiety. While some participants were working, others were in non-university-based schooling, and were volunteering in peer support groups for LGBTQ youth, another youth was running a trans youth of colour group in the GTA.

Only one participant lived with their biological parents. Others lived with friends or partners. One youth had experience with the CAMH GIC as a young adult. None of the others had been to

³²¹ Kiley signed a confidentiality agreement for the purposes of this research project.

³²² Singh et al 2013b *supra* note 281 at 97 check boxes #6 and #8.

a GIC. Two youths were on hormone therapies; one could not access them, and another was not interested in taking hormones.

Focus Group Process

The workshop took place at Springtide Resources, a feminist non-profit organization in Toronto that provided all-gender bathrooms, a kitchen and a fully wheelchair accessible private space. I provided the participants with a list of external support resources.³²³ I provided the participants with an honorarium, meals, snacks, and TTC tokens/taxi vouchers. All the youth were given access to digital cameras and memory cards, camera bags and chargers for the duration of the focus group. They also received legal information handouts about consent to treatment and capacity law and gender-affirming treatment subsidies in Ontario (see Appendix 5). The entire workshop totalled 11.5 hours over the span of two days: April 22 and 29, 2017. Unstructured discussion continued during mealtimes during which I took notes.

Image Creation

Photovoice training took place on Day 1 of the workshop after my introduction to the research project and a detailed description of project parameters and the meaning of consent (see Appendix 4). Kiley taught the participants a combination of situated visual ethics, image theory, photographic techniques, and aesthetic styles.

Situated visual ethics training and discussion consisted of consent for people of different ages and capacities and vulnerabilities, and techniques for how to protect people's anonymity, as well as using historical examples of how Black and Indigenous and trans people of colour have been

³²⁴ Attride-Stirling, *supra* note 326 at 389–390.

misrepresented in photographs since the 18th century as a way of exploring race and gender and agency. We also discussed what it means to have a “reasonable expectation of privacy” and where that expectation might apply and how the lines are blurred between public, and semi-private spaces. We strategized about how participants could avoid invading people’s privacy and how they could protect their own privacy with screens, staging, costumes and metaphors. Finally, we discussed how public and private photography can become illegal due to subject matter, invasion of privacy or the way the picture was taken and how to avoid those situations.

Participants also received general training on camera use including how to look, how to capture a shot, flash and lighting, rule of thirds, composing a shot, saving pictures, deleting pictures, utilizing different angles, zooming, considerations about nudity and undress and the implications of taking and sharing pictures within the project. We came up with strategies to photograph abstract concepts and protect anonymity by staging tableau photographs and using actors.

Kiley and I had written creative prompts for the Day 1 exercises selecting open ended and specific prompts. We also sent prompts for the week of shooting and gave the participants notebooks to carry with them over the week in which to record observations, questions and ideas.

Between the two workshop days participants were expected to take their photographs and record experiences in their journals. The second day of the workshop was held one week later. Participants each sent me ten photographs they chose based on how well they thought the photos related to the health care and consent related prompts in Appendix 2. We displayed the photos they had taken using a digital projector and viewed them together, writing down our own reactions and then listening to the photographers’ descriptions of the content and context of their shots. We related each photograph to the image creation prompts. As a group, we examined the

photographs using the rubric (Appendix 3) which I developed with Kiley. Our model shifted the emphasis from identifying why certain conditions exist and doing something to change such conditions, to asking about the photographer's and viewers' feelings, motives, representation and context.

Kiley provided some instruction on captioning and combining photos to make narratives, in which she recommended participants consider a series of questions to create their narratives. The participants were given time to work on captioning and ordering their images. They then shared their narratives and captions with the group.

Data Analysis

To begin my analysis, I immersed myself in the focus group data by looking at all of the photographs with captions and listened to all audio recording as I transcribed. In addition to what I heard and saw, I paid attention to what they did not show in photographs or say in discussion (while transcribing I had noted silences and moments of laughter in focus group sessions).

I played with the organizing themes by making an interconnected thematic network (see fig 2). Through this work, global themes (higher-level evaluative categories that bring greater interpretive meaning to the data themes) emerged.³²⁴

I used the same rubric Kiley and I offered to the participants (Appendix 3) for my own analysis of the participants' photographs. I borrowed five gazes from Lutz and Collins's theory as analytical tools.³²⁵ One way to understand gazes is as "lines of sight" of subjects, photographers and viewers and that may intersect inside or outside a frame.³²⁶ These

³²⁴ Attride-Stirling, *supra* note 326 at 389–390.

³²⁵ C Lutz & JL Collins, "The Photograph as an Intersection of Gazes" in *Reading National Geographic* (Chicago: University of Chicago Press, 1993) 187.

³²⁶ *Ibid* at 187.

intersections of gazes and the presence of multiple points of view made the act of taking and viewing photographs an interactive experience. The photographer's gaze, the editorial gaze, the subject's gaze and the researcher's gaze all offer insights.

I built my initial framework for coding transcripts and photos from themes in the extant literature I reviewed in Chapter 1.³²⁷ Then I augmented those categories with new concepts and themes emerging from the voices and images made by trans racialized youth as interpreted by me. Therefore, what I discuss in Chapter 5 is a blend of deductive and inductive analysis. The themes and sub themes that emerged from participant photographs and discussions will be laid out in detail in Chapter 5 in relation to specific photographs and the thematic network map.

Verification of Findings

Member checking allows marginalized participants the opportunity to tell the researcher if the transcripts are accurate, if analytic techniques used were effective, and findings reflect their own understanding of their experiences.³²⁸ The member checking session on August 30, 2017 was attended by all participants. I showed participants the themes that I had pulled from the photographs using the thematic analysis method. Together they had an opportunity to evaluate my grouping of themes for accuracy and suggest other themes. The group consensus was to add two themes: lack of accountability from service providers and avoidance of medical care.

³²⁷ Doctors' assumptions in Pyne 2018, *supra* note 35; Gatekeeping in Chang, *supra* note 120; and in X Sly Sarkisova, "Resisting the Binary: The Role of the Social Worker in Affirmative Trans Health Care" in Brian O'Neill, Tracy A Swan & Nick J Mulé, eds, *LGBTQ People Soc Work Intersect Perspect* (Toronto: Canadian Scholars' Press, 2015) 255; institutional barriers in Namaste, 2011 *supra* note 10; intersectional identities and resilience in Singh, 2013a *supra* note 50; Performance and self-image in Prosser, *supra* note 132; and in Thom, *supra* note 120; and avoidance of medical care in Hammond, *supra* note 78; Bauer et al, *supra* note 89; and legal barriers in Nussbaum, et al, *supra* note 28.

³²⁸ Wilson & Flicker, *supra* note 303 at 77.

After the checking session, I created a map working from the periphery inwards to the Global themes,³²⁹ grouping the themes into three broader categories: those that reflected disruptions to autonomy arising from doctors, health care providers and health care organizations; those that constituted systemic barriers to autonomous decision making; and finally, themes that reflected participants' responses to these disruptions.

Reflections on Methods in Hindsight

As I learned, there is no magic formula for Photovoice focus group fieldwork success but rather a gradual mutual testing of interactions and sharing of ideas between fieldwork co-facilitators and participants. I built critique of Photovoice on the work of Switzer, Holtby et al., and Wilson and Flicker³³⁰ on participatory visual methods. I knew from the works of hooks and Machida, that the method would be difficult for my participants because visual representation is not simple for multiply marginalized people who are under or misrepresented in popular cultural and scientific visual spaces. Therefore, the burden of self-representation can feel very heavy. The very act of taking photographs was challenging for focus group participants.³³¹ Taking photographs was not totally enjoyable for two of the participants. One person felt unsafe placing herself in a photograph in public or even being seen outdoors with a camera, and the other did not like looking at images of their face in photographs.

Despite these limitations, most of which I anticipated, the image production process did allow participants to use image production to challenge sameness within identity categories, and

³²⁹ Attride-Stirling, *supra* note 326 at 393.

³³⁰ Switzer, *supra* note 291; Holtby et al, *supra* note 206; Ciann Wilson & Sarah Flicker, *supra* note 303.

³³¹ For example, Participant #1 did not feel safe using the camera in public, especially on the first day when we took experimental shots on the street, Focus Group April 22, 2017 author's notes.

to portray their individual humanity, or to question the viewer's assumptions about trans racialized youth and health care decision-making.³³² There were several moments during the focus group process where I sensed that the participants felt what it could mean to experience autonomy in a world that erodes their autonomy. The image production process and the focus group sessions were at times a place where relationships of autonomy were fostered.

Conclusion

My methods attend to issues of epistemology, ethics and pluralism in legal, sociological, art-based and health science scholarship. The guiding concepts of legal pluralism and the notion of laws as tactics informed my methods, sending me to four categories of legal information. The role of trans racialized youth as legal actors animates my analysis in the next Chapter. In the Photovoice portion of this project, I was able to integrate anti-oppression praxis and relational principles using Singh's FPAR checklist and by integrating situated visual ethics into my use of Photovoice. Through this combination I was able to consider and adjust to meet the dynamic needs of the structurally vulnerable and trans racialized youth focus group participants as I attempted to answer my research question in the field.

³³² hooks describes this transcendent potential of art in her essay "Art on My Mind" *supra* note 201 at 8.

Chapter 4: Consent to Treatment in Normative Legal Sources

What truth claims does the law make about trans racialized youth? How do the processes of racialization in health care identified in Chapters 1 and 2 also interact with cisnormative processes found in authoritative clinical and diagnostic texts? How do the white/Western foundations of authoritative texts compromise the gender transitions of trans racialized youth?³³³ What can be revealed about decision makers' attitudes towards youth autonomy beyond the aspirational declarations of legislators? Recall that in Chapter 1 I argued that for trans racialized youth the barriers to attaining adult markers are so significant they find themselves in a stretched-out period of non-adulthood that has become "youthhood", extending well into, if not to the end of their 20s.

To answer these questions, I begin a pluralist examination of multiple sources of law using the list of factors affecting decision-making autonomy emerging from my exploration of relational autonomy in Chapter 2. The rationale behind my selection of these sources was fully canvassed in Chapter 3. Together, these sources form the pluralist legal container in which trans racialized youth attempt to develop and practice autonomy in health care contexts creating their own law as they share in their own words and photographs in Chapter 5. Part one begins with common law principles of autonomy, informed consent and legal capacity. I then zero in on doctrines developed specifically for minors. These doctrines foreground the period of statutory

³³³ I use the phrase "white/Western" conceptualized by G. Mahrouse, "Race-conscious transnational activists with cameras: Mediators of compassion," *International Journal of Cultural Studies*, 2008 vol. 11, no. 1, pp. 87 at 91. With that phrase Mahrouse captures "the complex confluence of race (whiteness) and nation (Canadian), geopolitical centre/margin location (Western) that produces the privilege that marks the work" of in this case the American Psychiatric Association and the WPATH.

consolidation presented in the next section. In section two I introduce the *Health Care Consent Act (HCCA)* and evaluate whether it creates the conditions conducive to a relational autonomy experience of health care for youth that I discussed in Chapter 2.³³⁴ In the third section I will contrast actual treatment of trans minors' and youths' health care interests in courts and tribunal decisions with the autonomy promises of the *HCCA*. In Part 2 I examine how health policy in the form of two authoritative texts, indirectly diminishes the selfhood and health of trans racialized youth. I show how the application of ostensibly neutral health insurance regulations fail to address the intersectional realities of trans racialized youth. The section ends with conclusions about whether the law lives up to its aspirations of autonomy in health care for trans racialized youth given its adherence to paternalism, binary gender categories and colour-blind language.

Part 1 Ontario's Legal Frameworks for Health Care Consent

Common Law Principles

The common law rule of consent to treatment is linked to the principle of autonomy. The leading case *Fleming v Reid* stated:

The common law right to bodily integrity and personal autonomy is so entrenched in the traditions of our law as to be ranked as fundamental and deserving of the highest order of protection. This right forms an essential part of an individual's security of the person and must be included in the liberty interests protected by s. 7. ...Indeed, in my view, the common law right to determine what shall be done with one's own body and the constitutional right to security of the person, both of which are founded on the belief in the dignity and autonomy of each individual, can be treated as co-extensive.³³⁵

³³⁴ *HCCA*, *supra* note 11.

³³⁵ *Fleming v. Reid*, 1991 CanLII 2728 (ON CA), <<http://canlii.ca/t/1p78q>>.

Thus, the right to bodily integrity and autonomy were affirmed as values that extended beyond physical security and protection of life to include the autonomy protecting and enhancing rule of consent to medical treatment. The case of *Malette v Shulman*, established that a physician's duty is to take instructions from capable patients even if they do not agree with the patient's treatment decision.³³⁶ Legal capacity is codified in statute and is comprised of two elements: the ability to understand the information about a treatment and secondly, the ability to appreciate the reasonably foreseeable consequences of taking or refusing a treatment.³³⁷ Because I argue that judicial attitudes towards minors extend to non-minor youth and influence the attitudes of health care providers, a brief description of the development of the mature minor doctrine is necessary.

The Mature Minor Rule

The mature minor rule reflects a judicial attempt to recognize a form of gradual autonomous health care decision making for a person under the age of majority.³³⁸ The doctrine permits a minor to make most decisions about health care without consent from parents, guardians or courts when a health care practitioner finds they have sufficient cognition and understanding.³³⁹ Recorded mature minor cases have primarily addressed the right to *refuse* invasive but life-

³³⁶ 1990 CanLII 6868 (ON CA), 72 OR (2d) 417 (CA) at 426.

³³⁷ *HCCA supra* note 11 at s. 4(1); *Starson v. Swayze*, [2003] 1 SCR 722, 2003 SCC 32 (CanLII), <<http://canlii.ca/t/1g6p9>> [*Starson*].
at para 78 [*Starson*]; LCO *supra* note 272 at 62-63.

³³⁸ The House of Lords first articulated the “mature minor” principle in *Gillick v. West Norfolk and Wisbech Area Health Authority*, [1985] 3 All ER 402., yet here the mature minor could only consent to treatments approved by a medical professional, thus conflating best interests and decision-making autonomy.

³³⁹ *AC v Manitoba (Director of Child and Family Services)*, [2009] 2 SCR 181 (SCC) (available on <http://canlii.ca/t/24432>), Abella J, at para 23 [AC].

saving treatments, on the grounds of religion or culture.³⁴⁰ In Ontario, the trend has been for judges to negate the decision-making autonomy of minors who want to refuse lifesaving treatment by endorsing the use of child protection laws.³⁴¹ Overall judges seem to find capacity where they agree with a minor's decision and find incapacity where they do not. While Canadian jurisprudence pre-2009 allows for a minor to be sufficiently capable to make most decisions, the judicial reluctance to encourage minors to develop autonomy skills, and to make decisions incurring significant risk, seems to be a sticking point driving litigation up to and including *A.C. v Manitoba*.

In *C. (A) v. Manitoba (Director of Child and Family Services)* the Supreme Court addressed the constitutionality of deploying child welfare legislation when doctors disagree with parents' and minor's refusal of a life-saving treatment.³⁴² *A.C.* clarified the national position at common law but did not formally change, or even mention, the legal situation in Ontario where no age threshold exists.³⁴³ Justice Abella interpreted the impugned provisions using a "best interests"

³⁴⁰ That physicians and children's aid societies litigate the refusal of treatments more than consent to treatment by minors was observed by Cheryl Milne, Justice for Children and Youth <https://www.ola.org/en/legislative-business/committees/administration-justice/parliament-36/transcripts/committee-transcript-1996-feb-20> at 930. For cases adjudicating a minor's decision to consent to treatment see *C. (J.S.) v. Wren (Alta. C.A.)*, [1986] A.J. No. 1166 (abortion consented to by minor was not considered tort of battery when parents sued the doctor who performed it) and *Cates v Kendall* where Court allows incapable adult to take growth hormones against mother's wishes by applying best interests analysis instead of finding capacity.

³⁴¹ The 12-year-old Jehovah's Witness in *Re L.D.K. (An Infant)*, 1985 CanLII 2907 (ON CJ) Yet as the exception the case engaged several special factors: long and painful treatment with a bad prognosis and her doctors supported her refusal of transfusion. But then see *Hughes v. Children's Aid Society of Metropolitan Toronto*, 1996 CanLII 8153 (ONSC), where a 13-year-old Jehovah's Witness's autonomy was denied, despite her s. 15 rights being violated on the basis of age and religion. Hughes had also challenged her doctor's finding of incapacity under the *Consent to Treatment Act*. Her parent's and her doctor's opinion of her capacity to consent depended on whether they agreed with her or not. Wilson J ruled that the threat to life was more important to the Court than her religious beliefs and prevented a finding of capacity justifying the use of child protection law under s. 1 of the Charter. This case foreshadows the majority decision in *A.C. supra* note 341.

³⁴² *A.C.* was a 14-year-old Jehovah's Witness. She consented to treatment but refused blood transfusions against her doctor's recommendation. Three psychiatric evaluations confirmed that *A.C.* understood the nature of the treatment and the consequences of refusing transfusions at *AC supra* note 341 para 82.

³⁴³ Minors in other provinces are not so lucky. For example, in Nova Scotia youth have to rely on the mature minors doctrine and interpretation in *A.C.* Newfoundland and Labrador minors between 16-17 years old are able to have

analysis imbued with the mature minor rule.³⁴⁴ While she said³⁴⁵ minors must be given a chance to demonstrate their capacity, she did not unequivocally state that capable youth's wishes would determine their health outcomes.³⁴⁶ Therefore *A.C.* leaves loopholes allowing for the judicial overriding of mature minors' wishes.

The decision eshews the typical atomistic understanding of autonomy and prefers to frame autonomy as a process that requires support to develop much like my application of relational autonomy. *A.C.* shows concern for religion, culture and parental pressure as external forces undermining independent decision making. The Court does not however, recognize that religion and culture can be part of a youth's development of selfhood. It failed to acknowledge systemic forces that impact decision making for racialized youth such as poverty, citizenship statutes and racism.³⁴⁷ Yet rather than encouraging fostering of conditions conducive to relational autonomy such as information sharing, or supportive decision making, the Court chooses protectionism.³⁴⁸ This protectionist attitude from the highest court influences other decision makers even where

their own capacity assessed and their reasoning considered even for decisions in life-threatening circumstances. Minors under 16 years still fall under the *Child and Family Services Act* and therefore have much more limited decision-making autonomy.

³⁴⁴ In addition to current evidence about adolescent development and autonomy, Abella referenced the Canadian history of the mature minor's rule and international covenants to confirm the principle that minors under 16 can indeed make informed and capable decisions about most aspects of their health. The best interests doctrine stems from the belief that parents are the natural guardians of their children and will act in their best interests. However, when family values clash with a minor's well-being in a socially accepted sphere then courts must act in the minor's best interests; for Abella J's reference see David N Weisstub, *Enquiry on Mental Competency: Final Report* (Toronto, ON: Publications Ontario, 1990) 1990 at 125-127 [*Weisstub Report*].

³⁴⁵ David Day, "Getting Respect: The Mature Minor's Medical Treatment Decisions: *A.C. v. Manitoba (Director of Child and Family Services)*," *Canadian Bar Review*, vol. 88, pp. 671-681, 2007 at 678.

³⁴⁶ Day argues that because the French version of Abella J's decision says that the mature minors' wishes "must be respected" that settles the issue in favour of capable minors under 16.

³⁴⁷ Binnie J, dissenting, takes a traditional libertarian view of autonomy at para 166 yet also recognizes that religious convictions can motivate an autonomous decision at *A.C.* *supra* note 341 at para 197.

³⁴⁸ While Binnie J's dissent found for the right of *A.C.* to make the decision to refuse life-saving treatment, Binnie relied on the typical legal understanding of autonomy as independence not interdependence.

the *HCCA* specifies that age is not a determining factor in Ontario and vis a vis other groups such as trans racialized youth who have reached the age of majority.

Paternalistic Decision-making post A.C.

Family court judges emboldened by *A.C.*, continue to ignore minor's autonomy, even that of capable 13 to 17-yr-olds. In *Cates v Kendall*³⁴⁹ parents with joint custody disagreed over the treatment of their son Ryan who was 19 years old but had the mental functioning of a 7-year-old and was considered incapable for this decision.³⁵⁰ Ryan wanted to take growth hormones recommended by his doctor, to improve the quality of his life. Ryan's father consented to the treatment, but his mother did not.

Judge Wilkinson reviewed both the *Starson* test for capacity and *A.C.* factors for assessing the capacity of a minor under 16 years old. It was clear Ryan understood the principle of informed consent and that he could withdraw his consent at any time.³⁵¹ While the judge affirmed Ryan's wishes, his ruling was based not on finding him to be a capable minor but on the Judge's own assessment of *what was best* for Ryan. This discussion demonstrates a judicial application of *A.C.* in which a court prefers a best interest analysis to a capacity to consent to treatment approach. In section three I will show the same pattern in Ontario cases involving the health rights of trans and gender non-confirming minors, that mirror the experiences of non-minor trans racialized youth in Chapter 5. Now I will evaluate the health care consent statute and whether it fosters autonomy practice for trans racialized youth.

³⁴⁹ 2011 SKQB 225, [2011] SJ No. 351.

³⁵⁰ *Ibid* at para 44.

³⁵¹ *Ibid* at para 56.

The Health Care Consent Act

HCCA has been described as "balancing competing interests of liberty and welfare".³⁵² The preamble states the following objectives: the provision of consistent rules across all health care settings, to enhance the autonomy of persons facing treatment, to promote communications and understanding between health care providers, patients, clients and to ensure a significant role for supportive family members when a person is incapable with respect to a treatment.³⁵³

A brief genealogy of the *Health Care Consent Act* is necessary to contextualize my critique of the gaps and inadequacies in Ontario's legislative and regulatory framework that undercuts autonomy for trans racialized youth. The *HCCA* is part of a suite of four statutes developed together over 15 years subject to the conflicting philosophies of three successive ruling political parties. The group of statutes created or amended by the *Consent and Capacity Statute Law Amendment Act, 1992*, were: *The Consent to Treatment Act*, the *Mental Health Act*, the *Substitute Decisions Act*, and the *Advocacy Act*.³⁵⁴ Subsequently *Bill 19, Advocacy, Consent and Substitute Decisions Statute Law Amendment Act, 1996* repealed the *Advocacy Act* and the *Consent to Treatment Act*. In 1992 these statutes were enacted and amended by the Liberals to clarify the common law on consent and substitute decision making in health care which had

³⁵² *Starson*, *supra* note 339 Major J at para 75.

³⁵³ *HCCA*, *supra* note 11, pursuant to s. 1 the definition of treatment excludes the following: a capacity assessment, health history-taking, the assessment or examination of a patient to determine the general nature of his or her condition, communication of an assessment or diagnosis, the admission to a hospital or other facility, a personal assistance service, a treatment that in the circumstances poses little or no risk of harm to the person, and anything prescribed by the regulation as not constituting treatment, *HCCA* s. 2(1).

³⁵⁴ *Consent and Capacity Statute Law Amendment Act, 1992*, SO 1992, c 32; *CTA* *supra* note 270; *Mental Health Act*, RSO 1990, c. M.7; *Substitute Decisions Act, 1992*, SO 1992, c. 30; *Advocacy Act*, *supra* note 270. The *CTA* had a fleeting existence before being replaced in 1996 by the *HCCA*. The *CTA* had narrower parameters than the current legislation only addressing consent related to treatment decisions whereas the *HCCA* encompasses admission to and confinement to treatment facilities and personal support services in homes.

become confusing even to legal experts for constituents and health care professionals and by the NDP to increase advocacy for vulnerable populations.³⁵⁵ In the 1996 amendments the PC government's objectives were to streamline consent and capacity procedures and to cut costs.³⁵⁶

The Period of Legislative Health Care Reform: 1989-1996

In the mid to late 1980s, at the behest of a Liberal government, three committees reviewed health statutes and health policy with a focus on vulnerable populations including youth.³⁵⁷ Their findings informed the legislative overhaul of the early to mid-1990s.³⁵⁸ The Committee on the Enquiry on Mental Competency, was asked to develop standards for determining mental capacity in minors.³⁵⁹ Its findings, known as the *Weisstub Report*, elevated the principle of autonomy and also expressed the need for best interests analyses to remain in future health care consent legislation vis a vis minors out of respect for family caregivers.³⁶⁰ The Report integrated both

³⁵⁵ Ernie Lightman & Uri Aviram, "Too Much Too Late: The Advocacy Act in Ontario" (2000) 22:1 Law 26 at 29-30.

³⁵⁶ *Ibid* at 26; "Government Picks bad time to Quit Advocacy: Bill 19 Increases Risk for Vulnerable People", Ontario Advocacy Commission, News Release, February 5th, 1996.

³⁵⁷ The Committee on the Enquiry on Mental Competency, (*the Weisstub Enquiry*), The Advisory Committee on Substitute Decision Making, and the Review of Advocacy for Vulnerable Adults, in LCO 2017 *supra* note 272 at 13. Three factors strengthened this initiative: increasing pressure from disability and mental health rights activists, political will from the NDP government who attempted to create less institutional and legal mechanisms to support vulnerable people; and, finally, the Supreme Court decision in *Eve*.

³⁵⁸ Sean O'Sullivan, *You've Got a Friend: A Review of Advocacy in Ontario* (Toronto, ON: Ministry of the Attorney General, 1987); Steven Fram, *The Advisory Committee on Substitute Decision Making* (Toronto: Ministry of the Attorney General, 1987). Elinor Caplan said November 22, 1995 regarding proposed repeal of the *Advocacy Act*, "I say that's unfortunate, because Fram's report, O'Sullivan's report and Manson's report all identified a definite need for advocacy services." https://www.ola.org/en/legislative-business/house-documents/parliament-36/session-1/1995-11-22/hansard#P441_105096 at 1740.

³⁵⁹ *Weisstub Enquiry supra* note 346 at 55 and 122. The Final Report on mental capacity and the importance of autonomy as a guiding principle for health law was referenced in *Starson*, A.C. and in the Ontario Legislative Assembly during debates between 1990-1996 over health care statutory reform.

³⁶⁰ *Ibid* at 137, 152.

concepts into a set of standards to guide legislators that eschewed age-based markers as reliable indicators of capacity.³⁶¹

The *Health Care Consent Act* of Ontario

The Presumption of Capacity

The *HCCA* codified the common law on consent and the two-part capacity test. There is no age threshold for capacity.³⁶² S. 11(1) outlines the four elements of consent. It must relate to the treatment, it must be informed, it must be voluntary, and it must not be obtained through fraud or manipulation. The meanings of “voluntary” and “misrepresentation” are not explained and are left up to regulatory colleges to explain to providers. As I detail below and in Chapter 5, this leaves room for providers to overlook coercive external factors acting on patients and to misinform patients about treatment possibilities based on providers’ ignorance or prejudice. The meaning of informed consent is described in s. 11(2) which states that reasonable information must be provided and questions arising about treatment must be answered. The statute, however, does not specify that information must be provided in a format or manner that the person can understand thus creating gaps for anyone with cognitive or intellectual differences or who communicates in a language other than English.³⁶³ The statute is clear that legal capacity to consent to treatment does not consist of one blanket assessment. Each treatment decision requires a new capacity assessment.³⁶⁴ For example, a trans youth might be found capable of deciding to

³⁶¹ *Ibid* at 55.

³⁶² The presumption of capacity without a statutory age threshold was consistent with the 1992 *CTA*.

³⁶³ LCO 2017 *supra* note 272 at 131 and 143. This means that a certified interpreter or attendant will be necessary to translate to ensure that the patient understands and can give consent.

³⁶⁴ *HCCA supra* note 11 at s.15(1).

start cross sex hormone therapy, but not capable of deciding to have a hysterectomy.³⁶⁵ Capacity still appears to be linked to cognitive abilities and functional decision making in the minds of many judges and clinicians.³⁶⁶ Because cognitive and functional capacity are the litmus test, youth who feel voiceless and powerless over their health can be viewed as incapable by clinicians when they refuse treatment.³⁶⁷ Trans racialized youth might struggle to demonstrate their decision-making capacity. For example, this way of assessing capacity could work against trans racialized youth who are English language learners unless they had access to a certified language interpreter.

Advocates voiced concerns that vague requirements for regulatory colleges to explain the legislation to professionals would maintain the status quo of large-scale misunderstanding of health consent law at the expense of youth.³⁶⁸ The Policy Statement #3-15 from the College of Physicians and Surgeons of Ontario (CPSO) was designed for this purpose. The policy expands requirements for doctors beyond the provisions of the *HCCA*. Overall, the document tells physicians to “respect patient autonomy”, yet autonomy is not explained, and the assumption is that patients *have* autonomy rather than framing autonomous decision making as a practice that must be fostered through relationships and structural equity.³⁶⁹

³⁶⁵ *Ibid* at s.15(2).

³⁶⁶ LCO 2017 *supra* note 272 at 15. Geist *supra* note 277 at 81.

³⁶⁷ Geist *supra* note 277 at 81.

³⁶⁸ Legislative Assembly, “Bill 19, An Act to repeal” Lawyer Linda Bohnen February 6, 1996, before the Advocacy Act, 1992, revise the Consent to Treatment Act, 1992, amend the Substitute Decisions Act, 1992 Committee on Administration of Justice, *Evidence*, 36 (February 6, 1996) https://www.ola.org/en/legislative-business/committees/administration-justice/parliament-36/transcripts/committee-transcript-1996-feb-06#P146_29940 at 930 (Linda Bohnen). Regulatory colleges were expected to assist health care providers in practical details of applying the *HCCA* resulting in wide variation across professions in key areas such as the provision of rights information.

³⁶⁹ CPSO #3-15 *supra* note 276 at 2.

CPSO members are reminded that for consent to be informed the appropriate information must be understood not simply provided. It advises that doctors consider communication barriers. To this end members should vary “the plainness of the language used, the modality in which the information is communicated, any literacy issues, etc.” and are cautioned against automatically relying on family members as interpreters citing family dynamics or conflict as a reason.³⁷⁰ This caution could certainly benefit trans racialized youth who are English-language learners and accompanied by family members, an experience mentioned by my focus group participants. The CSPO instructs doctors to chart all capacity and consent determinations with details and references as to whether parents were consulted or not and a summary of the information provided, and questions asked by the patient.³⁷¹ Doctors are told to ensure consent is provided by a minor even if parents/guardians are present.³⁷² The policy does not specify who to seek help from when capacity is hard to determine namely specialists in supportive collaborative youth decision making such as community advocates or the Office of the Public Guardian and Trustee.

The Supreme Court interpreted the common law and the *HCCA* on how mental illness impacts capacity in *Starson* in ways that should benefit trans youth. Firstly, the Court was clear that mental illness alone does not render one incapable.³⁷³ Secondly, when it comes to a diagnosed mental illness, the patient must be able to recognize the possibility that they have something resembling the diagnosed condition although they do not have to describe it as a

³⁷⁰ *Ibid* at 3, 8.

³⁷¹ *Ibid* at 9–10.

³⁷² *Ibid* at 5.

³⁷³ *Starson*, *supra* note 339 para 77.

negative or pathologized condition.³⁷⁴ Therefore, a gender dysphoria diagnosis, although located in the *Diagnostic and Statistical Manual of Mental Disorders* should not automatically make a trans youth incapable, nor as I contend throughout this chapter, should they have to describe themselves in pathological terms in order to meet the second part of the capacity test.

The *Starson* Court emphasized the cognitive and functional theory of capacity found in the *HCCA*.³⁷⁵ If the patient shows an ability to consider the parameters of the treatment decision including the nature and foreseeable risks of treatment; the available alternative courses of action; and, the expected consequences of not having the treatment, it does not matter if the patient's way of weighing the parameters is different from the doctor's. It is the *ability to appreciate consequences* that makes one capable.³⁷⁶ Furthermore refusing to speak to one's doctor does not automatically result in a finding of incapacity.³⁷⁷ This legal framework technically allows trans racialized minors and youth to make decisions on puberty blockers and surgeries without parental approval. Clinicians must ultimately be able to keep the wishes of guardians separate from those of capable minors and youth. They can do this by maintaining confidentiality or where youth and family members are in open disagreement, provide counselling supports for guardians who do not accept the capable choices of a youth rather than allowing guardians who disagree to exert pressure on the youth to capitulate.³⁷⁸ Health

³⁷⁴ *Ibid* at para 79; see also *O. (Re)*, 2005 CanLII 57809 (ON CCB) the patient was incorrectly found incapable because the doctor misapplied the *Starson* test and did not ask if the patient acceded to the possibility that some condition affected her mood or behaviour.

³⁷⁵ *Ibid* paras 80-81.

³⁷⁶ *Ibid* paras 80-81.

³⁷⁷ In *R.K. (Re)*, 2004 CanLII 57303 (ON CCB) a 17-year-old was found capable despite refusing to discuss her treatment with her doctor but had instead requested relevant information about her mental illness diagnosis and treatment from her nurses. She came to the capacity hearing clearly having read all the literature provided by her doctor and nurses.

³⁷⁸ Geist and Opler *supra* note 277; Geist *supra* note 277.

practitioners are well protected from liability for administering treatments that may not have been consented to, refused, withheld or withdrawn, as long as they believe "on reasonable grounds and in good faith to be sufficient for the purposes of the Act", that their actions were taken in accordance with wishes of a capable person.³⁷⁹ This provision should also encourage physicians to support capable minors and youth in situations where they are at odds with their parents or where the physician disagrees with the patient's capable informed decision without fear of civil liability or discipline for their regulatory College.³⁸⁰

Legislative Debate Over the Decision-Making Autonomy of Minors

It is clear from the record that the legislative intention was to recognize the decision-making autonomy in health care of minors. Nonetheless the precise question of whether children and youth should have the right to direct their own health was debated in the legislature on several occasions.³⁸¹ Minister Lankin and Minister Wilson's original position was to set 16 years as the

³⁷⁹ Pursuant to s. 29 of the *HCCA* treatment can only be administered without consent to a capable person in an emergency where there is a communication barrier due to language or disability if steps have been taken to assuage the communication problem even if unsuccessful and there is no way to communicate in time to prevent serious bodily harm and significantly there is no reason to believe the person does not want the treatment.

³⁸⁰ No cases exist where a minor's capable informed decision was overrode by physician or a hospital. All of the judges *find the minors incapable*, and the SDMs incapable if the court is ordering a minor to be treated. In each case the *Child and Family Services Act* (now the *Child and Youth Family Services Act*) was activated and no challenge to the incapacity finding occurred under the *HCCA*. *Hamilton Health Sciences Corp. v. D.H.*, 2014 ONCJ 603 (CanLII), <<http://canlii.ca/t/gf8sg>> note that doctor did not chart the finding of incapacity at para 39; *Children's Aid Society of Toronto v. L.P.*, 2010 ONCJ 320 (CanLII), <<http://canlii.ca/t/2c4m0>> at 123; *T.H. v. Children's Aid Society of Metropolitan Toronto*, 1996 CanLII 11981 (ON SC) Wilson J wanted to decide all issues and Consent and Capacity Review Board was not allowed to review the incapacity finding as the court was hearing an appeal on the finding of incapacity.

³⁸¹ Legislative Assembly, "Bill 109, An Act respecting Consent to Treatment" Standing Committee on the Administration of Justice, Debates, 35, (September 14, 1992) (Standing Committee for Bill 74 MPPs Barbara Sullivan, Norman Sterling, legal counsel Gilbert Sharpe); debated this point <https://www.ola.org/en/legislative-business/committees/administration-justice/parliament-35/transcript/committee-transcript-1992-sep-14>; subsequently, former Health Minister Elinor Caplan when commenting on the Conservative's amended bill, Legislative Assembly, "Bill 19, An Act to repeal the Advocacy Act, 1992, revise the Consent to Treatment Act, 1992, amend the Substitute Decisions Act, 1992", Debates, 36-1 (November 22 1995) https://www.ola.org/en/legislative-business/house-documents/parliament-36/session-1/1995-11-22/hansard#P441_105096 at 1740 (former Health Minister Elinor Caplan).

threshold for the presumption of capacity to make health care decisions.³⁸² Through debate and committee depositions from health care providers, social workers, and lawyers working with youth, the age threshold was eliminated altogether.

During the Committee stages of the *HCCA*, parents' rights activists, often with Christian affiliations, made protectionist arguments to curtail the decision-making autonomy of minors.³⁸³ Bill 91 was introduced by Standing Committee on Justice member Frank Klees as an amendment to the *HCCA* in November 1996.³⁸⁴ Klees identified the problem that:

The vast majority of Ontarians whom I speak to are not aware in the first place that children in this province can receive medical treatment of any kind without the knowledge of their parents, the only condition being that the health practitioner believes in his or her mind that the child is capable of making a decision. The reaction, when I discuss this with people across the province and in my constituency, is initially disbelief that this is the case in this province. The second reaction is indignation.³⁸⁵

To rectify this widespread ignorance of the law, Klees argued for the *HCCA* to include age-based thresholds and mandatory physician consultation with parents over decisions made by minors 16 years and younger. Confidentiality and options for supportive informed decision

³⁸² Ibid at 1740 (Elinor Caplan) Elinor Caplan https://www.ola.org/en/legislative-business/house-documents/parliament-36/session-1/1995-11-22/hansard#P441_105096 at 1740.

³⁸³ Legislative Assembly, Standing Committee on the Administration of Justice, *Evidence*, 35 (March 24 1992) at 1040 (Louis DiRocco of the Family Coalition Party); Legislative Assembly, Standing Committee on the Administration of Justice 36 (February 7 1996) at 902 (Rev. Lynch Roman Catholic Archdiocese of Toronto); and Legislative Assembly, Standing Committee on the Administration of Justice, *Evidence* 36 (February 13 1996) at 1000 (Diane Watts for REAL Women of Canada). Louis DiRocco of the Family Coalition Party https://www.ola.org/en/legislative-business/committees/administration-justice/parliament-35/transcript/committee-transcript-1992-mar-24#P138_29878 at 1040; Rev. Lynch Roman Catholic Archdiocese of Toronto https://www.ola.org/en/legislative-business/committees/administration-justice/parliament-36/transcripts/committee-transcript-1996-feb-07#P481_149033 at 902; and Diane Watts for REAL Women of Canada https://www.ola.org/en/legislative-business/committees/administration-justice/parliament-36/transcripts/committee-transcript-1996-feb-13#P933_308739 at 1000.

³⁸⁴ *Health Care Consent Amendment Act (Parental Consultation)*, Frank Klees, November 1996 [*HCCA Parental Consultation*] at 91.

³⁸⁵ Legislative Assembly "Bill 91, Health Care Consent Amendment Act (Parental Consultation)", *Debate*, 36-1 (November 18, 1996) (Frank Klees). Frank Klees, [Hansardontla.on.ca/hansardetitle/36-1/130-12.html](https://hansardontla.on.ca/hansardetitle/36-1/130-12.html).

making with non-family members is crucial for trans youth who may disproportionately experience heightened conflict with family members. Decisions about their health care have implications on their physical and mental health, employment and housing options.³⁸⁶ This amendment met with strong opposition from the Health Minister and the majority of MPPs and health care providers.³⁸⁷ Justice for Children and Youth, a legal clinic serving youth under 18 years, testified in 1992 and 1996 about the importance of autonomous decision making for their clients who were emancipated minors or youth in care. Staff lawyer Milne pointed out that youth were vulnerable to coercion and pressure: “They are generally accepting of adult authority. The image of the omnipotent adolescent refusing necessary treatment, although it exists, is not representative of youth in general.”³⁸⁸ This sentiment was echoed by MPP Dominic Agostino:

I am not sure how you tell 15-year-old kids who unfortunately are living on Yonge Street, in a blanket and maybe a couple of cardboard boxes, that to access medical treatment they would have to somehow track down, or make an attempt to track down, parents they may not have seen for a period of time or guardians who may not exist or individuals in their lives who may have done nothing more than abuse them and scar them for life. To force that prior to getting treatment I think is irresponsible. I think it's taking away the judgements that family practitioners, physicians, can make today.³⁸⁹

Physicians who had institutional support and access to resources such as the Hospital for Sick Children's Youth Clinic were well informed of legal rights for youth in health care and keen to

³⁸⁶ Malaika Hill and Rebecca Cheff, “Supporting Safe Spaces for Trans Health: Being an Ally” The Wellesley Institute, June 30, 2016 online <<http://www.wellesleyinstitute.com/health/supporting-safe-spaces-for-trans-health-being-an-ally/>>.

³⁸⁷ Health Minister Elinor Caplan stated her rejection of Bill 91 and quoted strong opposition to the Bill from College of Physicians and Surgeons of Ontario and the Ontario Medical Association *Health Care Consent Amendment Act (Parental Consultation)*, 1996 [*Health Care Consent Amendment Act (Parental Consultation)*, 1996], at 1110. Similarly, the East York Health Unit, Windsor Teen Clinic, and the Hospital for Sick Children all expressed alarm over Bill 91 at 1120.

³⁸⁸ Milne, *supra* note 342 at 930.

³⁸⁹ “Bill 91 *HCCA Amendment Act Parental Consultation*, *supra* note 386, pts 1120–1130.

protect youth autonomy, which they described as supporting youth involvement in decision making and confidentiality in accessing medical services. These physicians wanted family involvement, where appropriate and recognized autonomy development as a gradual process.³⁹⁰ While family physicians appeared to have more trouble applying consent law due to their close ties to parents or minor patients, clinic doctors recognized that youth often avoid family doctors because of the fear of breach of confidentiality.³⁹¹ Dr. Alan Goldbloom deputed:

As far as no age of consent, what that allows us to do, and in fact we have always functioned this way, is to recognize maturity when appropriate. It allows us to say to that 14-year-old, who either is very mature and appropriate or who may even be independent of his or her family, we recognize that individual's independence. It in no way prevents us from involving the family when it is appropriate to do so. In fact, the majority of teens we speak to want their family involved and we're happy to do that. It's in those circumstances when they don't and when family involvement may be an obstacle to care that we need that opportunity.³⁹²

Redress for Findings of Incapacity

The *HCCA* and the *Substitute Decisions Act* (SDA) were designed to be implemented with the robust protections of the *Advocacy Act* in place.³⁹³ The *Advocacy Act*, in its short life, provided

³⁹⁰ Legislative Assembly, Standing Committee on the Administration of Justice, *Evidence* 36, (February 7 1996) at 1140 (Dr. Alan Goldbloom and Dr. Christine Harris). Dr. Alan Goldbloom and Dr. Christine Harris https://www.ola.org/en/legislative-business/committees/administration-justice/parliament-36/transcripts/committee-transcript-1996-feb-07#P481_149033 at 1140.

³⁹¹ Dr. Alan Goldbloom *ibid* at 1140; and Legislative Assembly, Standing Committee on the Administration of Justice, *Evidence*, 35 (March 25 1992) at 1109 (Ontario College of Family Physicians, Dr. George Miller). https://www.ola.org/en/legislative-business/committees/administration-justice/parliament-35/transcript/committee-transcript-1992-mar-25#P205_60163 at 1109.

³⁹² Dr. Alan Goldbloom, *ibid* at 1150.

³⁹³ Former Minister of Health (1987-1990) Elinor Caplan speaking here as opposition Liberal MPP when Bill 19 was introduced: The package of legislation that is before us comes from years of identified need to address some very specific and fundamental issues. The package of legislation was required because prior to the legislation that was presented by the previous government, the NDP Rae government; there was no comprehensive legislation that dealt exclusively with areas of consent to treatment. You did have some dealt with under the *Mental Health Act*, some under the *Child and Family Services Act* under the responsibility of the Ministry of Community and Social Services, and some under the *Public Hospitals Act*, Ministry of Health. “Bill 19, An Act to repeal the *Advocacy Act*, 1992, revise the *Consent to Treatment Act*, 1992, amend the *Substitute Decisions Act*, 1992”, 2nd reading,

case management, formal rights advice and systemic advocacy to vulnerable adults.³⁹⁴ While the *Advocacy Act* did not offer advocacy services to minors, the overwhelming defeat of the Act in 1996 strengthened the overall role of family members as substitute decision makers of choice, a move which I argue eroded autonomy producing conditions for trans children and youth who were more likely to be at odds with their family members.³⁹⁵

Previously when *any* finding of incapacity was made a doctor had to give the patient information about how to contact a rights advisor.³⁹⁶ As Bill 19 was introduced in 1995, former Liberal Minister of Health, Elinor Caplan said, “I despair that this legislation removes all advocacy services, removes all rights advice.”³⁹⁷ This was the formally funded Advocacy Commission that provided public awareness about health care rights, enabling vulnerable youth (but not minors) to advocate for themselves and benefit from collaborative decision making when their families are unsupportive or unavailable. If doctors resent the considerable time required to attend hearings at the CCB, they may not consistently inform patients of their rights to contest findings or help them contact lawyers, actions which alone may not be effective if the person is a minor, is not comfortable in English, uses ASL or is intimidated by lawyers.

Legislative Assembly Debates, 36-1 (November 22 1995)https://www.ola.org/en/legislative-business/house-documents/parliament-36/session-1/1995-11-22/hansard#P441_105096 at 1730 (Elinor Caplan)..

³⁹⁴ In 1996 the *Advocacy Act* was repealed as part of the Harris government’s common-sense revolution to save money leaving vulnerable adults minimally protected under the remaining statutes. For example, when introducing Bill 19 Attorney General Charles Harnick described the Advocacy Act as intrusive and an “expensive and unnecessary adjunct to existing services” in “Bill 19” *ibid*: https://www.ola.org/en/legislative-business/house-documents/parliament-36/session-1/1995-11-22/hansard#P441_105096 at 1510-1700 (Hon Charles Hornick). MPP. Helen Johns said *ibid*: (Huron) https://www.ola.org/en/legislative-business/house-documents/parliament-36/session-1/1995-11-22/hansard#P441_105096 “What we are saying is that we’re going to eliminate the intrusive bureaucracy that came about through the last act and we’re going to restore the role of the family in the care and treatment of their family and their close family members. It’s very important to us to allow the family to make the decisions about what they believe is right for their family. This *Health Care Consent Act* does that for us.”

³⁹⁵ *AA supra* note 270.

³⁹⁶ *LCO supra* note 272 at 318-319.

³⁹⁷ “Bill 19” *supra* note 395 at 1750 (Elinor Caplan). Elinor Caplan https://www.ola.org/en/legislative-business/house-documents/parliament-36/session-1/1995-11-22/hansard#P441_105096 at 1750.

To illustrate this point through the operation of the *HCCA*'s own review tribunal, I examined decisions from the Consent and Capacity Board (CCB).³⁹⁸ S. 32(1) of the *HCCA* gives a person found incapable of making a treatment decision the right to challenge the health care provider's finding of incapacity before the Board.³⁹⁹ However, the *HCCA* only requires health care practitioners to provide rights advisor information when the incapacity finding pertains to psychiatric treatment.⁴⁰⁰ Thus, the bulk of the patients challenging findings of incapacity are psychiatric patients because they are the ones who are informed of their rights and the jurisprudence reflects this imbalance in access to review. Four reported CCB hearings were requested by youth diagnosed with gender identity disorder or gender dysphoria. While all the youth were challenging their involuntary status as psychiatric patients under the *Mental Health Act*, only two of the youth challenged findings of incapacity to make a decision to refuse psychiatric treatment under the *HCCA*.⁴⁰¹ No other formal evidence exists of trans youth challenging incapacity findings under the *HCCA*. This suggests that trans youth do not often use the CCB for redress. They then miss out on an autonomy- promoting process that could possibly improve their health outcomes.⁴⁰² Given that in the next chapter the focus group participants share several instances of health care providers' findings of incapacity that they disagreed with but left uncontested in part due to unfamiliarity with their legal rights. This is troubling.

³⁹⁸ I examined CCB cases that were decided between 1996 - 2018.

³⁹⁹ *HCCA supra* note 11 at s. 32(1).

⁴⁰⁰ *Ibid* at s.32.

⁴⁰¹ *KR (Re)*, 2011 CanLII 71437 (ON CCB), <http://canlii.ca/t/fnsrf>; *ED (Re)*, 2014 CanLII 14703 (ON CCB), <http://canlii.ca/t/g6cv0>; *CW (Re)*, 2016 CanLII 95339 (ON CCB), <<http://canlii.ca/t/gwwp3>>, *MO (Re)*, 2014 CanLII 14733 (ON CCB), <<http://canlii.ca/t/g6csx>> This youth was noted as being "native-Canadian", however for the other cases race/ethnicity was not mentioned.

⁴⁰² Geist & Opler, *supra* note 277 at 867.

Substitute Decision Making

The *HCCA* also provides a way to obtain a decision about health care treatment from a substitute, for someone who is incapable of consenting themselves. The *Act* recognizes that it is not always necessary (or expedient) to turn to an appointed decision-maker who has been through the legal procedures of the *SDA*.⁴⁰³ For example, the person's mental incapacity may be only short-term or for one type of decision. Health care providers can automatically apply a hierarchal list of substitute decision makers in which legal guardians such as parents are ranked 5th.⁴⁰⁴ Family members through blood, adoption and marriage ties are explicitly recognized creating a *prima facie* preference for traditional family members.⁴⁰⁵ The *HCCA* requires an application to be brought before the CCB under s. 33 by the incapable person or a person at least 16 years old who wishes to be appointed as the SDM of the incapable person. Trans people who are at greater risk of estrangement from or conflict with biological family would have to apply to have a chosen family member appointed as their SDM.⁴⁰⁶

⁴⁰³ *SDA*, *supra* note 356.

⁴⁰⁴ *HCCA*, *supra* note 11, s 20(1) 5.

⁴⁰⁵ *Ibid* at s.20(10).

⁴⁰⁶ Attorney General Charles Harnick stressed the goal of streamlining substitute decision making by family members for incapable patients through *HCCA* and amendments to the *SDA*, "Bill 19" *supra* note 386 at https://www.ola.org/en/legislative-business/house-documents/parliament-36/session-1/1995-11-22/hansard#P441_105096 1500 (Hon Charles Harnick); Jeffrey Cowan of the HIV and AIDS Legal Clinic of Ontario deputed on the need to expand the definition of family to include chosen family members trusted by gay men, HIV+ people and drug users who are more likely to be estranged from family, s Legislative Assembly, Standing Committee on the Administration of Justice, *Evidence*, 36 (February 8 1996) https://www.ola.org/en/legislative-business/committees/administration-justice/parliament-36/transcripts/committee-transcript-1996-feb-08#P944_297051 at 1600 (Jeffrey Cowan). In *EAM (Re)*, 2015 CanLII 19104 (ON CCB), <http://canlii.ca/t/gh4h0> the CCB chose a longtime friend and roommate over a brother as a SDM for an incapable man who had no spouse or children. The decision turned on the friend's demonstration of acting in EAM's best interests while the brother applied the brother's own preferences.

If an incapable person had appointed an attorney for personal care or a guardian of the person under the *SDA*, those would outrank parents and all relatives by marriage or adoption.⁴⁰⁷ This means that a person may use the *SDA* to designate, in advance of incapacity, the substitute decision maker of their choice. This SDM must be capable and at least 16 years old.⁴⁰⁸ Although, if youth are not aware of their rights and options for substitute decision making, they are very unlikely to have created powers of attorney for personal care under the *SDA*. It would seem from studies and focus group participants that where parents exist, doctors automatically refer to parents and relatives.⁴⁰⁹ For example, some doctors misunderstood the *HCCA* hierarchy and did not believe that trusted friends can apply to the CCB to trump higher ranking relatives.⁴¹⁰ This misunderstanding could restrain trans racialized youth's ability to choose a supportive SDM.

As the HIV and AIDS Legal Clinic of Ontario pointed out to legislators in the context of gay men and HIV+ people, incapable trans people might not want doctors to automatically appoint family members to make decisions for them.⁴¹¹ The statute does not facilitate amending the automatic SDM list. Enabling trans racialized youth to exclude unsupportive relatives from the *HCCA*'s s. 20 ranked SDM list without having to create a power of attorney under the *SDA* would mean youth could easily choose who would be in their circle of care for collaborative and supportive decision making. The College requires members "where possible" to inform patients of findings of incapacity and that an SDM will assist them in understanding the proposed

⁴⁰⁷ *HCCA*, *supra* note 11, s. 20(1) 1,2.

⁴⁰⁸ *SDA*, *supra* note 356.

⁴⁰⁹ Dr. Miriam Kaufman, "The Impact of the Ontario Consent to Treatment Act (Bill 109) on Adolescent Health Care," *Health Law in Canada*, vol. 15, no. 2, pp. 31–32, 1994; Interview of Dr. Miriam Kaufman, Pediatrician, Transgender Youth Clinic, the Hospital for Sick Children, August 2, 2017.

⁴¹⁰ Judith Wahl, *Health Care Consent and Advance Care Planning in Ontario*, Commissioned by the Law Commission of Ontario (Toronto, ON: Advocacy Centre for the Elderly, 2014) at 246.

⁴¹¹ See Jeffrey Cowan *supra* note 408.

treatment and be responsible for making the final decision.⁴¹² The decision making for incapable people is explained as per the *HCCA*'s reliance on substitute decision making. However, there is one reference to "collaborating" with patients and substitute decision makers that is never explained.⁴¹³ Where patients disagree with an incapacity finding or the highest ranking and appropriate SDM, doctors must tell them about the CCB and take reasonable steps to assist the patient, such as giving the patient the number for the lawyer referral service of the Law Society of Upper Canada.⁴¹⁴

Finally, in addition to selecting and contacting the correct SDM from the list, doctors must take reasonable steps to ensure that SDMs are informed of their duties and acting in accordance with the *HCCA*.⁴¹⁵ Given that some doctors find it onerous to provide so much information during a typical 20-25 minute appointment, there will be times when this dialogue is truncated or adequate accommodations for a patient are not made.

Professional Awareness of the Law

Throughout the 18 months of debates it was clear that many health care practitioners did not know the relevant common law, and this was attributed to cumbersome nature and legalistic language of the CTA.⁴¹⁶ Further evidence of this comes from MPPs, lawyers and doctors themselves. Mr. Tilson (MPP Dufferin-Pell) stated:

⁴¹² CPSO #3-15 *supra* note 276 at 7.

⁴¹³ *Ibid* at 1.

⁴¹⁴ *Ibid* at 7.

⁴¹⁵ *HCCA* ss. 21 & 37, and *M. (A.) v. Benes*, 1999 CanLII 3807 (ON CA), <<http://canlii.ca/t/1f9tr>> at para 23.

⁴¹⁶ Legislative Assembly, 36-1 *Debates* (November 27 1995) at 1600 (MPP Rosario Marchese); https://www.ola.org/en/legislative-business/house-documents/parliament-36/session-1/1995-11-27/hansard#P376_100718 at 1600; Dr. Allan Goldbloom the Hospital for Sick Children *supra* note 392 https://www.ola.org/en/legislative-business/committees/administration-justice/parliament-36/transcripts/committee-transcript-1996-feb-07#P481_149033 at 1140; Legislative Assembly, Standing Committee on the Administration of Justice, *Evidence*, 36 (February 13 1996) at 1600 (Dr. Dr. Cheryl Katz Ontario College of

Most medical people, in fact I don't think there was anyone, any medical health provider, who didn't come to me and say they were simply made dizzy by the proposals that were being put forward as to the very topics you're talking about. They didn't know which way to turn. They were worried about liability. They were worried about breaking the law. They didn't even understand it.⁴¹⁷

Dr Adrian Grek described his experience with the CTA as follows:

...perhaps because of my own inexperience in reading laws, but I did seek legal advice on the question as well. I've been unable to fathom just where my authority as a physician, as a psychiatrist in possession of such records, actually arises to release information in all sorts of circumstances in this connection, and it's not at all clear to me or to the lawyer who advised me.⁴¹⁸

And finally, health lawyer Linda Bohnen commented that:

My experience with the Consent to Treatment Act includes helping to write a detailed manual about it for hospitals, and I have given seminars about it to health professionals. I can tell you from personal experience that the Consent to Treatment Act has been very difficult to teach. Many health practitioners are simply bewildered by it. In my view, the fact that it is so complex has been a very real impediment to its being implemented.⁴¹⁹

As focus group participants documented in Chapter 5, doctors often preferred to consult with unsupportive parents even when no finding of incapacity had been made and the statute is clear

Family Physicians); *ibid* at 1530 (<https://www.ola.org/en/legislative-business/committees/administration-justice/parliament-36/transcripts/committee-transcript-1996-feb-13> at 1600; Steve Thomas, of Brockville Psychiatric Hospital Patient Council); Legislative Assembly, Standing Committee on the Administration of Justice, *Evidence*, 36 (February 20 1996) at 1200 (Dr. <https://www.ola.org/en/legislative-business/committees/administration-justice/parliament-36/transcripts/committee-transcript-1996-feb-13> at 1530; Dr. Peter Singer, University of Toronto Joint Centre for Bioethics); <https://www.ola.org/en/legislative-business/committees/administration-justice/parliament-36/transcripts/committee-transcript-1996-feb-20> at 1200; Ben Clemens *ibid*, at 904.

⁴¹⁷ Legislative Assembly, Standing Committee on the Administration of Justice, *Evidence*, 36 (February 6 1996) at 1110 (David Tilson PC) David Tilson PC MPP https://www.ola.org/en/legislative-business/committees/administration-justice/parliament-36/transcripts/committee-transcript-1996-feb-06#P146_29940 at 1110

⁴¹⁸ Legislative Assembly, Standing Committee on the Administration of Justice, *Evidence*, 36 (February 6 1996) at 1110 (Dr. Adrian Grek). Dr. Adrian Grek https://www.ola.org/en/legislative-business/committees/administration-justice/parliament-36/transcripts/committee-transcript-1996-feb-06#P146_29940 at 1110

⁴¹⁹ Linda Bohnen *Ibid* <https://www.ola.org/en/legislative-business/committees/administration-justice/parliament-36/transcripts/committee-transcript-1996-feb-06> - P146_29940 at 930 (Linda Bohnen).

that doctors are not liable for providing care when they properly have confirmed capacity and informed consent.⁴²⁰

A study of Ontario doctors' knowledge and attitudes to health consent law was conducted in 1996 just as the new *HCCA* came into force.⁴²¹ The participants were 15 doctors who had received a book on the new *Act* from the Ontario Medical Association and who worked in adolescent medicine at major hospitals in Toronto. The surveys covered the following areas: i) capacity to consent; ii) disclosure; iii) documentation in charts iv) addressing parent-child conflicts; and, v) feasibility of compliance with the new *Act*.⁴²²

The physicians said they always disclosed the most detailed information to the adolescent patients themselves not the parents, if parents were even involved.⁴²³ Less common was the situation where a patient wants something that parents disagree with. Only one participant stated that if the parents did not agree with the youth, the procedure would not be carried out. Most participants felt that the new *Act*, because it had no age threshold, would pit doctors against parents, since they did not have to succeed in helping parents and the child reach an agreement.⁴²⁴ Eleven participants said they already disliked the time and loss of income required to attend incapacity hearings before 1996. Some expressed frustration with legal processes especially the involvement of lawyers. Other concerns expressed by doctors were mixed. Doctors thought that the new *Act* made it easier to treat mature patients without their parents knowing or

⁴²⁰ See *infra* 598 and also below at 147.

⁴²¹ Catton et al, *supra* note 115; Urman et al, *supra* note 115.

⁴²² Urman et al, *supra* note 115 at 138.

⁴²³ *Ibid* at 140.

⁴²⁴ Geist corroborates that doctors held this concern in 1996 in Geist, *supra* note 277 at 84.

when parents were not available.⁴²⁵ Doctors also felt that compliance with the *HCCA* would be harder because they found the consent process and the capacity process vague and six doctors found capacity hard to determine since the new *Act* did not spell out the assessment criteria the way the *Consent to Treatment Act* did.⁴²⁶ This pattern has continued despite recent statutory affirmations of the common law position.⁴²⁷

While some doctors have embraced the greater decision-making autonomy afforded minors and youth under the *HCCA*, others remain inadequately informed about the presumption of capacity. For example, what to do when parents disagree with a minor or youth's decision, make capacity assessments and find a youth incapable for a decision.⁴²⁸ This inconsistent medical environment leaves trans minors and youth in danger of reduced autonomy.

Mandating Public Awareness

Legal advocates for youth critiqued the draft *HCCA* and continue to point to its failure to mandate how public awareness of rights would be achieved in an arena where ignorance of rights has drastic consequences.⁴²⁹ Justice for Children and Youth testified that:

The legislation the way it's written now just applies to the health care providers. You're not going to find a young person who's going to go and look up the act. You're not going to find very many people who are going to go look up the act to see what their rights are. They're going to be faced with a situation and told that there's a decision made, and at that point, without knowing that there's a piece of legislation that governs them,

⁴²⁵ Notably, doctors appeared to be unaware that minors already possessed these rights both under the 1992 *CTA* and at common law prior to 1992.

⁴²⁶ Urman, *supra* note 115 at 144; *O. Reg. 19/95*, s.4(4). See also Geist, *supra* note 277 at 84.

⁴²⁷ Catton et al, *supra* note 103. Recent confirmation of physicians' continued widespread misunderstanding of *HCCA* especially the SDM hierarchy, was documented by the Advocacy Centre for the Elderly in 2014 see Wahl, *supra* note 412 at 246.

⁴²⁸ Geist, *supra* note 277 at 285.

⁴²⁹ Community Legal Education Ontario has no youth specific, trans specific or *Health Care Consent Act* specific legal resources on its website <https://www.cleo.on.ca/> searched on January 10, 2018.

without knowing that they have a right to appeal the decision if they don't like what's happening, you can have all the plain language you want, but it's never going to be read.⁴³⁰

Recall that the physician's duty to provide rights advice and the required information itself was stripped down between the *CTA* and the *HCCA*.⁴³¹ Meanwhile the barriers to challenging incapacity assessments remain very high for structurally vulnerable clients.⁴³² For example, one legal advocate cautioned that: "Without the requirement that the young person's rights be communicated to them, we are going to just see young people's rights being run roughshod over."⁴³³

All things considered, the *HCCA* provides the skeleton for trans youth autonomy in health care, and professional guidelines add some flesh to that frame. Autonomy-enhancing factors such as trusting relationships with health care providers, knowledge of legal rights and the CCB process can shift the finding from incapable to capable when a youth feels like they have a forum in which to articulate and own their health care choices.⁴³⁴ And yet statutory aspirations and regulatory cautions belie the intersectional realities of trans racialized youth in clinical and adjudicative contexts causing legal advocates to describe the *HCCA* as "a step backward for human rights and for personal autonomy."⁴³⁵ What might happen when a trans youth makes a

⁴³⁰ Milne, *supra* note 342 at 930.

⁴³¹ *CTA supra* note 270 at s. 9 requires a health care provider to give anyone over 14 years a notice that they can receive rights advice whether they are in a psychiatric facility or not, and the physician must inform the rights advisor that a finding of incapacity has been made if the person requests rights advice or if the finding was made in a psychiatric facility. The rights advisor must promptly meet with the person in question and explain the process of challenging a finding of incapacity. The *HCCA* makes no mention of the provision of rights advice, however s. 17 instructs health care providers to follow their regulating body's guidelines about what information to provide to a patient found incapable and how to provide it.

⁴³² LCO 2017, *supra* note 272 at 139–141. Other statutes that explicitly mandate public education about rights are the *Provincial Advocate for Youth Act* 2007 SO 2007, c. 9, *Accessibility for Ontarians with Disabilities Act* 2005 SO 2005, c. 11, and the *Ontario Human Rights Code supra* note 4.

⁴³³ Milne, *supra* note 342 at 930.

⁴³⁴ Geist, *supra* note 277 at 82.

⁴³⁵ Milne, *supra* note 342 at 940.

treatment decision to choose a treatment such as gender affirming surgery that will cause them to be infertile for the rest of their life, or when their parents disagree about the decision to use puberty blockers (whose effects are reversible). These considerations are at the heart of the cases in the next section where the autonomy and health of trans youth are undercut by binary legal gender categories or buried beneath their parents' custody disputes.

Trans Youth in Jurisprudence

The decisions of courts and tribunals are an influential source in which the articulation of legal norms and the application of principles about consent or capacity for trans youth can be observed. Decisions also reveal evidence of adjudicators' conceptions of gender categories and transness. One challenge for my inquiry was that trans youth are absent from Canadian jurisprudence up until the late 2000s when human rights complaints were made against provincial ministries, private businesses and school boards.⁴³⁶ Moreover, the race/ethnicity of parties is rarely noted, so with few exceptions I could not determine who is racialized, and how that affects the decision maker.

To get at decision makers' views about trans youth I had to broaden my scope from Ontario case law to include cases from across Canada and the decisions of Ontario administrative tribunals such as the Consent and Capacity Board and the Ontario Health Services Appeal and

⁴³⁶ *CF v Alberta (Vital Statistics)*, 2014 ABQB 237 (available on <http://canlii.ca/t/g6ll9>) 23 yr old trans woman sought accurate birth certificate; *Lewis v Sugar Daddy's Nightclub*, 2016 HRT0 347 (available on <http://canlii.ca/t/gnxvq>), young trans masculine person was assaulted and ejected from the nightclub; *TA v Ontario (Transportation)*, 2016 HRT0 17 (Interim Decision) (available on <http://canlii.ca/t/gmtmv>) non-binary youth seeks accurate driver's licence; *DB v Toronto District School Board*, 2015 HRT0 1592 (available on <http://canlii.ca/t/gm911>). Many other complaints settled before going to the tribunal and are therefore unreported, Jacquelin Pegg, Inquiry Analyst, Legal Services and Inquiries, Ontario Human Rights Commission, Personal Correspondence (2018).

Review Board. The gender identity of minors is the focus of conflict in several child custody and access cases examined here. This small body of cases is useful because it updates what we know about judicial attitudes towards trans people since the 1990s marriage and social entitlement cases involving adult trans litigants. More importantly, what this examination of custody cases reveals is that trans minors' health care rights under the *HCCA* are ignored, therefore, suppressing the development of their autonomy practices. The experiences of older youth focus group participants in Chapter 5 confirm the continuation of this unfortunate pattern of neglect of their statutory rights and the diminished conditions of their autonomy in health care in Ontario.

Gender as a Legal Category

Despite the social changes and legislative reforms discussed in Chapter 1, gender remains conflated with sex in legal decision making in Canada and is still considered a legitimate legal category for everyone including trans youth.⁴³⁷ This judge's comment about a youth's request for accurate pronoun use is one example of lingering legal cisnormativity:

She even requested that the Tribunal refer to her as a boy. It is with great respect that the Tribunal explained to her that sex is also a juridical reality. The Tribunal should not add to the confusion and will therefore treat a juridical reality as it is; which will not prevent the president of the Tribunal of being empathetic to her difficult situation.⁴³⁸

The judge forces the youth to identify based on his understanding of legal gender categories as fixed and binary, instead of revising the law to fit the youth's expressed identity. Even in decisions where trans litigants were successful in gaining legal recognition of their trans

⁴³⁷ I cited human rights code amendments and Vital Statistics Acts in Chapter 1.

⁴³⁸ *Protection de la jeunesse — 0968* (QCCQ January 21, 2009), [2009] RJQ 1215 (QCCQ) at para 1.

subjectivity, I argue that judges' understanding of gender/sex is ultimately limiting.⁴³⁹ In the case of *C.F. v. Alberta (Vital Statistics)* a trans feminine youth won her s. 15 Charter challenge to a Vital Statistics statute that prevented her from obtaining a gender/sex accurate birth certificate.⁴⁴⁰ Justice Burrows writes a compassionate and progressive decision affirming that a trans person should not be forced to have genital surgery just to prove they are trans and obtain accurate official identification.⁴⁴¹ Burrows rejects the Attorney General's convoluted argument that trans people should not be ashamed of their gender and hide by modifying their (bio)logic identification, thus incurring discrimination and potential violence over mismatched identification documents.⁴⁴² The judgement emphatically critiques the genitocentric regulation of gender in a way that forces trans people to out themselves as a "third sex" and suffer harms.⁴⁴³ However, there are two major problems with how Burrows theorizes gender/sex. Firstly, he says: "Alberta's response does not appear to appreciate that C.F. like everyone else accepts that there are but two sexes. She does not consider herself a member of a third sex. She considers herself female."⁴⁴⁴ With this statement he declares his common-sense belief in sexual dimorphism and

⁴³⁹ One exception is the case of *KAB v Ontario (Registrar General)*, 2013 ONCJ 684 (CanLII) at paras 8 and 12, in which Cohen J found that a 17 year old trans racialized youth of a single mother had withdrawn from parental control due in part to transphobia. She was not in the mother's custody, as she was not in the mother's physical care or control, and K.A.B. made all her own decisions about residence, education, and health care. Accordingly, she had the right to apply on her own, without parental consent, for a change of name to support her social transition.

⁴⁴⁰ ABQB April 22, 2014, 2014 ABQB 237 (CanLII), <http://canlii.ca/t/g6ll9> [C.F.].

⁴⁴¹ *Ibid* at para 25; Burrows J references evidence from the U.S. National Transgender Discrimination Study (see Chapter 1) and cites social science of discrimination against gender variant people as a result of legal categories of gender.

⁴⁴² *Ibid* at para 52; Sharpe coined the formula, "(bio)logic" to describe legal reasoning that sex is assigned at birth immutably forever based on external genitalia, *supra* note 51 at 39-56.

⁴⁴³ *Ibid* at para 29; "Genitocentric" is a term used by Sharpe in "From Functionality to Aesthetics: the Architecture of Transgender Jurisprudence" in Murdoch University Electronic Journal of Law, Volume 8, Number 1 (March 2001) at para 14. According to him, genitocentric legal reasoning decides sex based on one's genitals. In one version natal sex is determined and forever fixed by doctors on the basis of external genitalia at the time of birth. In the second version while sex may change, for a legal transition, genitalia must be surgically altered to reflect that change.

⁴⁴⁴ *Ibid* at para 57.

erases the existence of a gender continuum and the subjectivity of non-binary trans people. Secondly, in relying on the medical evidence of C.F.'s commitment to her felt gender, he repeatedly confirms her gender based on the permanence of her transition, and her desire to "be full time in the female gender role for the rest of her life."⁴⁴⁵ These statements deny the possibility of a fluid gender that can change over the course of one's life more than once. The evidence that gender/sex can fluctuate is a reason why it is unsound as a legal category especially for the purposes of identification.⁴⁴⁶

This type of legal reasoning is based on recognizing and repairing what Sharpe calls a *psychological cultural/social disharmony*.⁴⁴⁷ This model is becoming more prevalent in Canada where it has been increasingly applied by human rights tribunals since the turn of the second millennia.⁴⁴⁸ This adjudicative move away from previous legal determinations of sex based on natal sex and anatomical "correctness" is positive. The model instead accepts a plastic view of sex/gender and allows for a social and relational understanding of gender/sex. For example, when Waters challenged British Columbia's provincial health insurance plan (MSP) for failing to pay for his phalloplasty the Tribunal commented that:

What MSP did was to leave Mr. Waters in the middle of a surgical process: not being totally a male in physical appearance and function and being unable and unwilling to return to being a physical female. The dignity and self-respect of a person is most often dependent on how he sees himself and how he is seen through the eyes of society. In this case, Mr. Waters is not a complete and fully-functioning physical male. He is aware

⁴⁴⁵ *Ibid* at paras 12, 66, 67.

⁴⁴⁶ See also *XY v. Ontario (Minister of Government and Consumer Services)*, 2012 HRT0 726 (CanLII), [2012] OHRTD No. 715 for an earlier complaint involving a non-youth. For a fulsome study of this topic see Wipfler, A. J. (AJ) N. (2016) "Identity Crisis: The Limitations of Expanding Government Recognition of Gender Identity and the Possibility of Genderless Identity Documents", *Harvard Journal of Law and Gender*, 39, 401–463.

⁴⁴⁷ Sharpe 2002, *supra* note 51 at 59.

⁴⁴⁸ *XY v. Ontario (Government and Consumer Services)*, 2012 HRT0 726, *Forrester v. Peel (Regional Municipality) Police Services Board et al*, 2006 HRT0 13, *Kavanagh v. Canada (Attorney General)*, 2001 CanLII 8496 (CHRT), *Dawson v. Vancouver Police Board (No. 2)*, 2015 BCHRT 54.

of this everyday. When he moves in the community, he is inhibited in what he can do, namely being naked and urinating as a man without difficulty.⁴⁴⁹

Notably, the decision supports Waters' desire for external affirmation of his gendered selfhood, while at the same time colluding with traditional expectations of males and masculinity and ultimately agreeing that Waters has the wrong body for a binary male.

Some legal commentators and scholars who agree that genitocentrism is based on faulty legal reasoning and discriminates on grounds of sex and gender identity endorse this model.⁴⁵⁰ While this model allows for greater acceptance of transgender and non-binary identities as opposed to only "post bottom surgery" transsexuals, as Bettcher observes, this reasoning is still based on the wrong body pathology theory.⁴⁵¹ As a result, psychological and psychiatric evaluations continue to hold disproportionate weight in judicial decision making. As Hooley writes: "It is time to assert that there is no wrong body and that all bodies are alright whatever their state or genital status. It is the power of the norm and of medicine and law which take the cultural meanings made of biology as ultimate truth that sustains our deviant status, body regulation and discrimination."⁴⁵² It is this disconnect between theory and practice, that I argue is mirrored by law with respect to the lived experience of its trans youth subjects.

Against this backdrop of evolving change about some aspects of gender/sex in law I will now turn to analyse four cases where the health consent rights of trans minors are trumped by family

⁴⁴⁹ *Waters v. BC Medical Services Plan*, 2003 BCHRT 13 (CanLII), <<http://canlii.ca/t/h09z2>> at para 225.

⁴⁵⁰ McGill and Kirkup, *supra* note 39 and Shauna Labman, "Left in Legal Limbo: Transsexual Identity and the Law" (2001) 7 *Appeal: Review of Current Law and Law Reform* 66.

⁴⁵¹ Bettcher, *supra* note 226 at 386-388; Sharpe 2002, *supra* note at Chapter 4 "Reform Jurisprudence".

⁴⁵² J Hooley, "What is this thing called 'Gender Dysphoria'?", *Newsletter of the Transgender Liberation Coalition Inc* (1994) 6.

law best interest's analyses where current and future health matters related to their gender identity are central to both the conflict and the custody order.

Trans Minors' Health Autonomy Rights Buried in Family Law

The cases examined in this section illuminate how judges interpret the applicability of the *HCCA*'s consent provisions in custody and access proceedings. Justice Perkins frames the conundrum as follows:

I have been struggling with how to balance or reconcile the powers and duties of the court under the Divorce Act to make custody and access orders in the best interests of the children, on the one hand, with, on the other hand, the children's growing entitlement to personal autonomy and respect of their views and preferences.⁴⁵³

Custody and access decisions result in orders that include directives about health-related matters. Such directives are especially pivotal for trans and gender non-conforming minors who have a greater propensity towards engagement in their own health care. Custody however is not a monolith. It refers to a bundle of rights and responsibilities regarding a child which can be separated and allocated to any person with custody of the child.⁴⁵⁴ Medical decision-making authority is bundled with education in custody orders, however some orders involve specific therapeutic directives which arguably engage the *HCCA* with its presumption of capacity for all

⁴⁵³ *N.L. v R.R.M.* 2016 ONSC 809 (CanLII), 76 RFL (7th) 428 Perkins J, at para 137.

⁴⁵⁴ *Chou v York Regional School Board* [2005] OJ No 1374 (QL) (ONSC) at para 21; ss. 20(2) and (3) Children's Law Reform Act, RSO 1990, c. C.12 which governs custody and access when not arising from a divorce.

persons. The best interests of the child analysis guide the custody decision, and I argue that health-related issues be construed broadly as treatment requiring corollary consent.⁴⁵⁵

With no clear appellate ruling on the applicability of the *HCCA* consent provisions to minors in family court orders, lower court judges have taken different directions. There is obiter dicta recognition that minors close to 18 years old need to consent for health-related orders.⁴⁵⁶ There is also diversity of opinion in lower courts about the scope of the term “treatment” under the *HCCA* because a broad interpretation increases the instances where a person’s consent is required.⁴⁵⁷ Furthermore, while the majority of judges favour paternalistic therapeutic solutions to family law matters, some judges recognize that to foster autonomy means allowing capable minors to make choices that courts and parents do not agree with.⁴⁵⁸

Lawyers have made arguments that health-related incidents of custody should be decided under health consent law not family law. In *N.K. v A.H.*, a British Columbia case, a father sought to prevent his racialized 11-year-old child from transitioning by attempting to wrest custody

⁴⁵⁵ Applicable sections of the *CLRA*: s. 24 (b) the child’s views and preferences if they can reasonably be ascertained and (d) the ability and willingness of each person applying for custody of the child to provide the child with guidance and education, the necessities of life and any special needs of the child. Applicable sections of the *Divorce Act*, RSC 1985, c 3 (2nd Supp), s. 16(6) authorizes the court to “impose such other terms, conditions or restrictions in connection therewith as it thinks fit and just”.

⁴⁵⁶ *Leelaratna v. Leelaratna*, 2018 ONSC 5983 (CanLII), <<http://canlii.ca/t/hvgtc>> a 12 yr old is ordered to attend therapy against his and his mother’s wishes although Audet J states that consent would likely be required for older children before a therapeutic order could be issued at para 67.

⁴⁵⁷ For definition of treatment under *HCCA* see *supra* note 11. *N.L. v R.R.M.* 2015 ONSC “But the definition of treatment under the Health Care Consent Act is much broader than psychotherapy and counselling” Perkins J at para 129; affirmed in *Barett v Huver* 2018 ONSC 2322 where the case was not decided on this point, however, Shaw J, stated in obiter dicta that reunification therapy was treatment by regulated health professional and the consent of 12 and 15 yr olds would be required under the *HCCA* at paras 28, 31, 35, 42, 47. Cases that defined treatment narrowly and thus avoided engaging consent provisions of *HCCA* are *Testani v Haughton* 2016 ONSC 5827 ordered therapy for 13 yr old who refused therapy through custody order, but considered consent of parents to their own therapeutic order; and *E.T. v. L.D.*, 2017 ONSC 4870 (CanLII), <http://canlii.ca/t/h5c2r> where consent of children 9, 12 and 16 years of age was not required for an order to attend family reunification therapy because the therapy was held not to be treatment and the psychologist was not considered a regulated health professional at para 60.

⁴⁵⁸ *J.K.L. v. N.C.S.*, 2008 CanLII 30289 (ONSC), at paras 192–193 Turnbull J ordered therapy for a 13 yr old and erred in thinking *HCCA* had an age threshold of 16 years for legal capacity.

from the gender-affirming parent.⁴⁵⁹ The father also wanted the mother and child to terminate their retainer with barb findlay, queer activist lawyer, and to stop using other trans positive services and resources. The father's wishes would certainly have undermined his child's ability to access information about being trans, therefore thwarting conditions for autonomy development for the child. Deciding the case in neither parents favour, Justice Skolrod identified the ongoing conflicts as between the parents. As required by statute, the judge prioritized the child's best interests by making sure they had their own litigation guardian, so in a sense, protecting their legal autonomy.⁴⁶⁰ That said, the judge ignored arguments made by the mother's lawyer that the urgent issues of the possible use of puberty blockers before the onset of irrevocable pubertal changes pertained to health law not family law.⁴⁶¹ The judge could have rejected the father's motion on the basis that the court cannot actually grant the father legal authority to prevent the child from making medical decisions with their doctor by way of a custody order.⁴⁶² The judge did not consider that under s. 17 of the British Columbia *Infants Act* the minor would have been able to make their own transition-related health decisions.⁴⁶³

⁴⁵⁹ *N.K. v A.H.* 2016 BCSC 744 (Prince George) (CanLII) available on, <<http://canlii.ca/t/gpphw>>, See also *Halton Children's Aid Society v G.K.*, BRK 2015 ONCJ 307 available on <<http://canlii.ca/t/gjf2d>> [*Halton*]. The decision does mention that the minor is racialized, however I received this information in personal communication with their lawyer barb findlay, October 19, 2018.

⁴⁶⁰ *Divorce Act* (RSC, 1985, c. 3 (2nd Supp.)) s. 16(8); *Family Law Act* [Sbc 2011] Chapter 25 s. 37 (1) In making an agreement or order under this Part respecting guardianship, parenting arrangements or contact with a child, the parties and the court must consider the best interests of the child only and s. 37(2)(a) (2) To determine what is in the best interests of a child, all of the child's needs and circumstances must be considered, including the following: (a) the child's health and emotional well-being:.

⁴⁶¹ A point made argued by barb findlay and shared in our personal communication about the case.

⁴⁶² For decisions making this argument see *Barrett v Huver*, and *N.L. v R.R.M.*; and *Children's Aid Society of Toronto v. M.S.*, [2018] OJ No. 123, 2018 ONCJ 14

⁴⁶³ *Infants Act* [RSBC 1996] Chapter 223, ss. 17(2), (3). Note that s. 17(3)(b) gives infants consent as long as the health care providers agrees that the decision is in their best interest.

In *Halton v. G.K.*, a Children's Aid Society tried to apprehend two children from their mother and place them in their father's custody with the Society's supervision.⁴⁶⁴ The position of the Society and the father was that the mother was forcing "S.", a four-year-old child assigned male at birth to behave and dress like a girl against the child's wishes.⁴⁶⁵ The mother had been trying to support the child in developing their autonomy skills by seeking out community-based resources and other trans positive doctors.⁴⁶⁶

Justice O'Connell found discrepancies in both parents' evidence regarding their four-year-old child's gender identity and gender expression.⁴⁶⁷ In that context, her ruling gave paramount weight to the expert medical evidence provided by Dr. Joseph Bonifacio of the Gender Clinic at the Hospital for Sick Children in Toronto.⁴⁶⁸

Dr. Bonifacio recommended providing the child with a variety of options for behaviour and appearance without gendering such options and also reducing the number of medical professionals treating the child to avoid shaming and pathologizing the child.⁴⁶⁹ The judge was uncomfortable with the provision asking for either party to notify the Society if S. "expresses the desire to dress as a girl" because the meaning of dressing like a girl was unclear and seemed to incur negative consequences to S. if they did decide to "dress as a girl".⁴⁷⁰

⁴⁶⁴ *Halton*, *supra* note 460 at para 1.

⁴⁶⁵ *Ibid* at paras 13-14.

⁴⁶⁶ *Ibid* at paras 43-44.

⁴⁶⁷ Section 24 of the CLRA details the factors that a court shall consider when making a determination with respect to custody and access, and these factors act as a useful guide for a best interests analysis under the Divorce Act *supra* note 461 in *A.F. v. D.G.*, 2012 ONSC 764, at para 185.

⁴⁶⁸ Dr. Bonifacio explained the stages of gender development in young children, distinguished between gender expression and gender identity, and then cautioned against pushing a child towards any one gender identity based on their gender expressive preferences *ibid* at para 51.

⁴⁶⁹ *Ibid* at para 52.

⁴⁷⁰ Dressing like a girl was established as wearing skirts and dresses from the girls' section of a clothing store, not just wearing pink and purple coloured clothing *ibid* at paras 111-112.

Dressing like a girl was established as wearing skirts and dresses from the girls' section of a clothing store, not just wearing pink and purple coloured clothing. The judge amended the provision to read: "Neither party shall unilaterally dress S. as a girl or force S. to take on certain gender roles." In the event that S. wanted to "dress as a girl" the party who had care of S. would notify the other parent and the CAS to decide how to proceed.⁴⁷¹ The judge's exposition in this case showed the artificiality of determining gendered behaviour for a child. The judge affirmed that gender identity and social roles are binary, in other words distinct for girls and boys.⁴⁷² The order contained directives about treatment for the child by paediatricians and a family physicians as well as the Hospital for Sick Children's Transgender Youth Clinic.⁴⁷³ Yet despite the presence of a gender specialist from a progressive transgender youth clinic, and ongoing medical treatments contemplated, there was no mention of the developing autonomy in decision making of the child who would eventually have the right, under the *HCCA*, if capable, to make their own decisions about medical transition.⁴⁷⁴

In a third case where a non-binary 12-year-old child was the subject of a custody dispute between their non-binary mother and their father, Dr. Bonifacio again provided expert testimony.⁴⁷⁵ The judge's opinion on the child's gender identity was as follows:

The child's decision to identify as gender neutral has been made, even if influenced by the mother, what is relevant is which parent is best able to support the child. I am guided by the evidence of Dr. Bonifacio who testified that the parents should just wait and see and let the child function. I find that it is the father who is the parent most likely to just

⁴⁷¹ *Ibid* at 114.

⁴⁷² *Ibid* at 113.

⁴⁷³ *Ibid* at 161.

⁴⁷⁴ Ultimately, the father withdrew his appeal based on the amended gender-variance alert condition and the judge asked the parents to continue the shared schedule as before.

⁴⁷⁵ *J.P.K. v. S.E.*, 2017 ONCJ 306.

let N. be and explore his gender issues whereas the mother has difficulty letting N. be his own person.⁴⁷⁶

Weight was given to the fact that the father was also attending a Gender Identity Group with the child. Ultimately the father was granted full custody over the child as he was found to be more responsible, stable and would cooperate with health professionals better than the mother.⁴⁷⁷ The child had seen a psychologist and both parents took the child to different therapists.⁴⁷⁸ The custody order grants the father “sole decision making authority over all major issues regarding education, religion, medical, healthcare and counselling decisions”.⁴⁷⁹ This may be standard language for a custody order, yet nowhere else in the decision is there reference in obiter dicta to the minor’s health consent rights under the *HCCA*, to alert the parents of the existence of such rights.⁴⁸⁰

The last custody case is *B.D v M.M.* where the gender fluid child was nine years old.⁴⁸¹ The father, a middle-class engineer was unsupportive of social transitioning, let alone medical transition. The mother, a worker at a sexual assault centre was supportive of the child’s gender exploration. The child was comfortable expressing their gender with the mother and was upset and repressed about their gender with the father. The father felt the mother outsourced her parenting to professionals. In fact, the father’s central allegation in the case is that the child’s

⁴⁷⁶ At para 184.

⁴⁷⁷ Zisman J, at paras 196-198.

⁴⁷⁸ *Ibid* at para 26.

⁴⁷⁹ *Ibid* at para 207.

⁴⁸⁰ Notably the minor had been able to access free community support services, and out of pocket psychological services because various family members were able to take them to appointments and pay for uninsured services. The child was also a student in the Toronto District School Board which compared to school boards in smaller cities and towns, offers several supports for gender-expansive students, which however are culturally/racially white dominated. The minor might learn about their rights through community supports but as per the court and the parents would be unaware of their rights.

⁴⁸¹ *Davies v. Murdock*, 2017 ONSC 4763 (CanLII), <<http://canlii.ca/t/h59c6>>.

gender expression is scripted by these professionals and the mother and not a reflection of the child's true desires and wishes.⁴⁸² Recall this idea of self-awareness as a concept key to autonomy development of self from Chapter 2. Also, recall that this development is not status and is informed by internal and external factors like culture, religion and social interactions.

In terms of final procedures for gender affirming decision making for the child who is nearing puberty, the Judge ordered:

With respect to medical and psychological decisions or mental health regarding Rosie/James' gender non-conformity the parents shall follow the recommendations of Dr. Stephen Feder, director of the Gender Diversity Clinic at CHEO or another doctor at the clinic if Dr. Feder is no longer able to provide services for Rosie/James. If there is a dispute as to those recommendations or their implementation, the parties are first to attempt to resolve the matter through the exchange of written proposals. If the dispute remains unresolved after the exchange of written proposals on the issue, it is strongly recommended the parties attend mediation or retain the services of a parenting coordinator to attempt to resolve the dispute, and share the costs proportionate to their incomes. If the dispute remains unresolved, the parties may return the matter to Court for determination.⁴⁸³

The above order is issued even though earlier the Judge held that:

As previously indicated, the parties' ability to communicate, cooperate and collaborate in order to meet the needs and interests of their children has become severely compromised over the course of these proceedings. In fact, the conflict and dispute between the parents caused the children's doctor Dr. Kaplan-Myrth to withdraw her services in February 2016. As of December, 2016, the parties had not been able to agree on an appropriate replacement.

This again is a case where the judge does not show an awareness of a minor's legal rights conferred by the *HCCA*, perhaps because counsel did not argue it. Cis parents are becoming aware of gender identity and gender expression and the treatments available for trans and gender

⁴⁸² *Ibid* at paras 26-27.

⁴⁸³ *B.D. v. M.M.*, [2017] OJ No. 4121, 2017 ONSC 4763 *supra* note 483 at para 192 and 31.

nonconforming children. Indeed, the child and their parents would be best served to be informed of such rights and cautioned that the child should be supported in making their own health care decisions about transitioning.⁴⁸⁴

The language used by most judges in these four decisions and custody orders would not disrupt a parent's belief that they can exercise full control over their trans children's ongoing health care decisions. Furthermore, minors approaching puberty (4-12 yr olds), becoming aware of their legal rights to health care decision making autonomy is crucial in the face of potentially unsupportive parents and ignorant or intractable health care providers.⁴⁸⁵ And indeed, if both parents *agreed on not* supporting a gender-variant or trans youth, and the child did not have access to groups, resources, progressive clinics, the youth would likely not be able to transition in the manner they wanted to because of ignorance of their rights. And as we have seen from the literature and as the focus group participants confirm in the following chapter, this capability to self-advocate is key for the autonomy of trans racialized youth in health care at any age.

Several of the decisions reveal attempts to grapple with gender and age-based roles for children within the contested site of the family. Yet despite the relevance of informed consent to treatment and the legal irrelevance of age in the *HCCA*, the judicial direction of lower courts is towards consolidation of control over minors' decision-making autonomy in the hands of

⁴⁸⁴ In *Leelaratna supra* note 457 at para 78, while Audet J ordered therapy for a resistant teen, she recognized that uncooperative older teens may make a therapeutic order inoperable, and she considered the means to "convince an older child to cooperate" such as using the child's own counsel or by meeting with the judge.

⁴⁸⁵ Where youth were parties to proceedings and thus represented by their own counsel they argued for their autonomy in health care even if judges who both referenced "autonomy" declined to decide on the *HCCA* consent provisions: see *S.G.B. v. S.J.L.*, 2010 ONCA 578 (CanLII), <<http://canlii.ca/t/2cgvq>> where a 16 yr old with learning disability was granted intervenor status and a stay of a far-reaching custody order by Mesbur J [2010 ONSC 3717 at para 25] giving his mother authority to make all health related decisions for him due to his special needs, full-time school attendance, and being under 18; and see *N. L. v. R.R.M.* 2016 ONSC 809 17 and 18 yr olds asserted consent to treatment rights under *HCCA* which Perkins J affirmed in obiter dicta at para 113 but decided case against making a therapeutic order of counselling saying children had withdrawn from parental control and not subject to any custody order.

parents. Conditions that foster autonomy for minors continues to be a determining factor later in ensuring trans youth's access to healthcare as we will see in the following chapter.

In summary, when it comes to the application of the *HCCA* to minors and youth in various legal contexts, the two values of autonomy and protection continue to vie for precedence. As Paré argues, while legislation ostensibly recognizes the principle of autonomy for minors, "the protectionist approach remains integral to decision making".⁴⁸⁶ Autonomy, when referenced does not incorporate relational autonomy, for example *HCCA* rights education, recognition of chosen family or collaborative supported decision making. The conservative and paternalistic nature of the judiciary is alive and well. We see this in terms of court-ordered therapy for minors and older youth, circumventing the *HCCA*, and when it comes to enforcing binary gender and passing health-related decisions over to the guardians of trans and gender-non conforming minors.⁴⁸⁷ The data of Chapter 5 confirms that the trans racialized youth who are not minors still experience the same treatment.

Part 2 The Regulation of Transness through Authoritative Texts

Doctors have the *HCCA* and the policy documents from their professional colleges to guide them through legal issues of consent. In their dual role as health care providers and as gatekeepers to health care they also reference nosologies and clinical texts. In this next section I

⁴⁸⁶ Paré, *supra* note 107 at 108.

⁴⁸⁷ Manitoba and Alberta still balance the mature minor rule against child welfare legislation in situations where medical legal establishments paternalistically seek to protect the minor from their own decisions. New Brunswick has an age-based presumption in its legislation, and its Appeal Court affirmed the mature minor rule in *Pole v. Region 2 Hospital Corporation*, 1994 CanLII 4470 (NB CA). There were disagreements between judges about whether *parens patriae* jurisdiction was still valid despite the combination of the mature minor rule and the *Medical Consent of Minors Act*, SNB 1976, c M-6.1.

examine the two most authoritative clinical texts applicable to trans racialized youth: the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* and the International Standards of Care (SoC) issued by the WPATH. I contend that both texts work against the autonomy of trans racialized youth in health care in two distinct ways. Firstly, the formula derived from the *DSM* and absorbed by the SoC is coded to recognize and affirm normative gender roles, middle class realities and is configured to white/Western cultural standards.⁴⁸⁸ Secondly, the SoC eligibility requirements deselect racialized youth because of the SoC's lack of intersectional and anti-racist analysis. Then I explain the implications for trans racialized youth when these authoritative texts are absorbed within insurance regulations. Finally, I provide a contrast by discussing a set of local guidelines developed with trans community knowledge and input for primary care practitioners. This brings us closer to Chapter 5, the phenomenology of four trans racialized youth, who will deepen this inquiry through their own words and photographs.

Coercive Pathology

Psychiatric institutions in particular have made themselves experts on trans people through professional committees that produce authoritative diagnostic and clinical texts such as the *DSM* and the SoC.⁴⁸⁹ When governments sanction professional expertise through policy, physicians then control access to trans health care. Furthermore, placing mental health professionals in the gatekeeper role undermines trust in therapeutic relationships and reduces the benefits of therapy

⁴⁸⁸ Sarkisova *supra* note 329 at 262. I use the phrase “white/Western” as conceptualized by G. Mahrouse, “Race-conscious transnational activists with cameras: Mediators of compassion,” *International Journal of Cultural Studies*, 2008 vol. 11, no. 1, 87 at 91. With that phrase Mahrouse captures “the complex confluence of race (whiteness) and nation (Canadian), geopolitical centre/margin location (Western) that produces the privilege that marks the work” of in this case the American Psychiatric Association and the WPATH.

⁴⁸⁹ Sarkisova *ibid* at 261 and Chang, *supra* note 120 at 47.

for trans people.⁴⁹⁰ As I showed through the literature in Chapter 1, and as youth confirm in Chapter 5 there is a formulaic narrative that trans people know they must recite when seeking treatments. Sarkisova, encapsulates the dialogic process early described by Denny, Stone and others in Chapter 1 into the concept of “coercive pathology”.⁴⁹¹ Sarkisova describes it as a “pathologizing psychiatric narrative [that] narrows the possibilities for what it means or can mean to be trans”.⁴⁹² Coercive pathology ultimately concludes that the formula for diagnosis mimics cisnormative narratives, desires and paths.⁴⁹³

The Nosology of Trans Youth

The SoC endorses the *DSM*, a manual of mental disorders, produced by the APA as an authoritative classification system for the health conditions of trans people.⁴⁹⁴ The *DSM* authors have been primarily white, male, middle-class, high-status psychiatrists.⁴⁹⁵ They determine what constitutes a mental illness based on grouping symptoms of so-called abnormal behaviours. Psychiatry is socially and culturally situated, thus the authors of the *DSM* operate within their own social constructions of abnormality.⁴⁹⁶ Numerous studies have pointed to racial, cultural and

⁴⁹⁰ Lev, *supra* note 130 at 53-54.; Chang, *supra* note 120 at 49; Sarkisova, *supra* note 329.

⁴⁹¹ See Stone 1991, *supra* note 125; Denny 1996, *supra* note 132; Prosser, *supra* note 132 and in Namaste 2000, *supra* note 75; Spade 2003, *supra* note 52 at 2 and Thom, *supra* note 132.

⁴⁹² Sarkisova, *supra* note 329 at 263. See also Prosser, *supra* note 132, and Spade 2003, *supra* note 52 and Dean Spade, “Mutilating Gender” in Stryker & Whittle, *supra* note 226 at 315. Trans people have shared fictional and autobiographical narratives since the 1960’s as ways of writing themselves into existence and challenging the pathological medical model. See Janet Mock, Imogen Binnie, Kai Cheng Thom, and Dylan Scholinski through blogs, magazine articles, photographs and novels that challenge medico-legal stereotypes.

⁴⁹³ Sarkisova, *supra* note 329 at 262.

⁴⁹⁴ SoC, *supra* note 273 at 5-6. The SoC also references the International Classification of Diseases (ICD) now on version 11 released June 2018 which is used more widely around the world, has a primary care focus and is published by the World Health Organization, <http://www.who.int/classifications/icd/en/>. I address the *DSM* in my research as it is the primary diagnostic text used in Canada.

⁴⁹⁵ Preface to Caplan and Cosgrove, *supra* note 123 at xx.

⁴⁹⁶ M. Linder, “The Construction of Illness,” in Caplan and Cosgrove *supra* note 123, 3–7 at 3.

gender bias in the creation of *DSM* diagnoses.⁴⁹⁷ Despite these critiques and resulting changes to definitions of illnesses over decades, *DSM* authors continue to view nosology as atheoretical and race and gender neutral. While it is beyond the scope of this chapter to recount the long and turbulent history of trans nosology a brief summary of nosological evolution helps establish my argument that the APA is a driving force in coercive pathological narratives for trans racialized youth.⁴⁹⁸ From 1980 to 2013, the APA classified trans minor youth under “Gender Identity Disorder in Children and Adolescents”. In 2013, the APA changed the classification to Gender Dysphoria (GD) in the *DSM-V*. Currently GD describes a marked incongruence between one’s experienced gender and one’s sex characteristics, how one is perceived and gendered in society, respectively for more than six months and accompanied by “clinically significant distress or impairment in social, occupational, or other important areas of functioning.”⁴⁹⁹ Often during adolescence, GD is worsened by intense distress about body image, and the wish to alter physical and behavioural sex characteristics.⁵⁰⁰

Whereas distress over one’s physical and psychological incongruence could be partially remedied by medical treatments, the phenomenon of transphobia also causes intense distress and though widespread is not considered pathological.⁵⁰¹ While the 2013 nosological change certainly decreased the pathologization of transness and shifted the focus to the experience of

⁴⁹⁷ R. Littlewood, “Psychiatric Diagnosis and Racial Bias: Empirical and Interpretative Approaches,” *Social Science and Medicine*, vol. 34, no. 2, 141–149, 1992; Alisha Ali, “Racism in Psychiatric Bias”, in Caplan and Cosgrove, *supra* note 123; N. Javed, “Clinical Cases and the Intersection of Sexism and Racism,” in Caplan and Cosgrove, *supra* note 123, 77–80.

⁴⁹⁸ For history of the psychiatric classification of transness see Jemma Tosh, “Working together for an Inclusive and Gender-Creative Future: A Critical lens on ‘Gender Dysphoria’” in Meyer & Pullen-Sansfaçon, *supra* note 53, 41.

⁴⁹⁹ *DSM-V*, *supra* note 3.

⁵⁰⁰ Mieke Roder et al, “Health-related quality of life in transgender adolescents: Associations with body image and emotional and behavioral problems” (2018) 19:1 *Int J Transgenderism* 78.

⁵⁰¹ For evidence of psychological impacts of transphobia on trans youth see ODSP appeal cases from the Social Benefits Tribunal in this chapter *infra* note 575.

distress over transphobia and gender incongruence, the diagnostic criteria for GD barely changed.⁵⁰²

The World Professional Association for Trans Health Standards of Care

The WPATH SoC version 7 are the latest internationally prescribed clinical standards regarding transition related care for transsexual and transgender people.⁵⁰³ They cover the components of a gender dysphoria diagnosis, puberty suppression, hormone replacement therapy, mental health assessment, requirements for surgery, surgical procedures and postoperative care. The SoC are also the officially accepted protocols for provincially insured gender affirming surgeries in Ontario. Ontario's Ministry of Health and Long Term Care (MOHLTC) adopted these standards when developing insurance coverage regulations for surgeries.⁵⁰⁴ However, analogous to the widespread misapplication of health decision making law in Ontario, it is reported that many health care providers apply outdated clinical standards and believe that diagnosis is required for hormone replacement therapy instead of a less coercive and less pathologizing assessment.⁵⁰⁵

The SoC have improved since they were originally released as the Harry Benjamin Standards in 1979.⁵⁰⁶ For example, Version 7 incorporates harm reduction principles and explicitly

⁵⁰² Kelley Winters, "Methodological Questions in Childhood Gender Identity 'Desistence' Research", (Paper delivered at the 23rd WPATH Health Biennial Symposium, Colorado, February 16, 2014), online: GID Reform Weblog <gidreform.wordpress.com/2017/02/10/revisiting-flawed-research-behind-the-80-childhood-gender-dysphoria-desistance-myth/>; and Tosh, *supra* note 500 at 56.

⁵⁰³ SoC, *supra* note 273.

⁵⁰⁴ MHLTC SRS, *supra* note 274.

⁵⁰⁵ Interviews with Kai Cheng Thom (May 2016), Jordan Zaitzow (April 2016 and March 2017) and see also SoC, *supra* note 273 at 166–167.

⁵⁰⁶ The Harry Benjamin International Gender Dysphoria Association (HBGDA) is the precursor to the WPATH. It was named after the endocrinologist who started treating transgender youth in the United States. There have been six versions of the Standards of Care for Gender Identity Disorders, published in 1979, 1980, 1981, 1990, 1998, and 2001.

acknowledges the North American and Western European research foundations of the SoC.⁵⁰⁷

Notwithstanding these aspirational statements and their improvement over previous standards, v7 continues to espouse the professional mental health medical model where individuals with a disease require treatment. Additionally, they impose requirements that contraindicate against access to treatments for trans youth of colour.

Cisnormativity, misogyny and pathologizing elements within the *DSM-V* and the SoC are easy to identify because the language used is explicit, and indeed substantial critiques on these topics exist.⁵⁰⁸ The SoC are most easily understood by and meant to be used by people who have a medical or health education because of the abstract and psychiatric lexicon they deploy. Frequently used terms like “patient”, “management”, “clinical” and “eligibility” are pathologizing to a trans reader. Recalling that the SoC incorporates the *DSM’s* misogynist gender binary, recently some have highlighted concerns that the SoC remains problematic for gender non–binary, trans feminine people:⁵⁰⁹ a *DSM-V* diagnosis of the mental illness of Gender Dysphoria; a one-year test of living in your felt gender role without surgery; a three-month mental health screening and assessment before any type of treatment; an identifiable history and narrative of cross-gender affiliation.

While racism is harder to pinpoint, the core required elements of the SoC are damaging to trans people and gender non-conforming people of colour. The reader can recall the observations of Stone and Ms. Major from Chapter 1 about the cultural whiteness of the HBGDA/WPATH ideology of transness and the racism within the clinical encounter. The way that authoritative texts affect trans racialized youth differently is seen through what is *not* acknowledged and in the

⁵⁰⁷ SoC, *supra* note 274 at 1, 2, 33, 36, 44.

⁵⁰⁸ Tosh, *supra* note 500; Sarkisova, *supra* note 329; Chang, *supra* note 120.

⁵⁰⁹ Sarkisova, *supra* note 329 at 261–265; Pyne 2018, *supra* note 35.

application of the diagnostic and eligibility criteria. To illustrate the first point, there is no mention of social determinants of health, intersectional identities, structural or systemic barriers to care or the importance of community generated knowledge anywhere in the SoC. In a reference about which youth are accessing treatment through gender clinics the SoC says:

The percentages of treated adolescents are likely influenced by the organization of health care, insurance aspects, cultural differences, opinions of health professionals, and diagnostic procedures offered in different settings.⁵¹⁰

Beyond this vague comment, the SoC does not dig deeper into the different impacts and experiences and clinical needs of racialized, disabled trans people. There is minimal acknowledgement of white/Western research foundations and the continued white North Americanness of the SoC Committee and International Selection Committees.⁵¹¹ And finally, the SoC uncritically elevates mental health professionals especially psychiatrists whose field has been critiqued for its implicit white/Western bias. Devoid of meaningful anti-oppressive critique, there is no signal of awareness that racism, ageism, classism and ableism are embedded in the culture of the APA or the WPATH, let alone action to change the practices.⁵¹²

Application of the following SoC eligibility minimum criteria has a differential impact on trans racialized youth: expression of a recognizable story, with familiar symptoms, signs of physical and social commitment to the gender role, being stable, and having family support.⁵¹³

As Pyne's research suggested in Chapter 1, trans racialized youth are largely absent from the

⁵¹⁰ SoC, *supra* note 273.

⁵¹¹ Of the 34-member Revision Committee for version 7, only nine were not from the USA, and of that nine only one was not from Western Europe or Canada. The International Advisory Group Selection Committee was entirely North American, and the International Advisory Group itself had only two members from the Global South, SoC *supra* note 273 at 111.

⁵¹² Michel Foucault, *Psychiatric power: lectures at the Collège de France, 1973-74* (New York: Palgrave Macmillan, 2003); Caplan and Cosgrove, *supra* note 123; Ali, *supra* note 499.

⁵¹³ SoC *supra* note 273 at 19.

white middle class client base using Ontario's progressive clinics and being fast-tracked to their desired gender.⁵¹⁴ In its section on the assessment and treatment of children and adolescents with GD the SoC states that the best way to reduce distress for pubertal transgender adolescents (with a GD diagnosis) is by taking puberty suppressing medication and gender affirming hormone treatment.⁵¹⁵

The adolescent specific section of the SoC is also problematic because the section wholeheartedly accepts the highly contested clinical research by Dr. Kenneth Zucker and his school of psychiatry.⁵¹⁶ For example, in the section on the difference between children and adolescents the SoC describes the higher rates of dysphoria continuing into adulthood for adolescents over children, based on the 1995 research by Drs. Zucker and Bradley and subsequent research by one other researcher.⁵¹⁷ While there is no doubt that not all children who show cross gender and gender bending behaviours are actually trans, relying uncritically on methodological and ethically biased studies by Dr. Zucker undermines the credibility of the SoC.⁵¹⁸ Dr. Zucker was a proponent of using conversion therapy on minors, especially children as the following passage shows:

The new *early gender transition* therapeutic approach stands in marked contrast to other therapeutic approaches in which efforts are made to help a child feel more comfortable with a gender identity that matches his or her birth sex, in part to avoid the complexities of lifelong cross-sex hormonal treatment and sex-reassignment surgery. My impression is that *the early gender transition approach will result in more children persisting in*

⁵¹⁴ Pyne 2018, *supra* note 35.

⁵¹⁵ SoC *supra* note 273 at 19.

⁵¹⁶ Zucker's research is cited 17 times in the Adolescent section alone in SoC from 10-20.

⁵¹⁷ SoC, at 11.

⁵¹⁸ Thomas D Steensma & Peggy T Cohen-Kettenis, "A critical commentary on 'A critical commentary on follow-up studies and "desistence" theories about transgender and gender non-conforming children'" (2018) 19:2 Int J Transgenderism 225.

their desire to live as a member of the other gender, which is, in effect, a rather interesting social experiment of nurture.⁵¹⁹ [emphasis added]

He equates the production of cissexuals and cisgender people with clinical success and believes that early gender transition cannot be neutral despite being reversible. This thesis argues that even the use of the word "persistence" with reference to gender dysphoria connotes pathology to the state of being transsexual or transgender which is indeed a tension throughout the SoC. For example, the SoC clearly states that it is now considered unethical to use conversion therapy. Yet, it continues to require *DSM-V* diagnoses and mental health assessments of trans youth by "qualified mental health professionals" before any kind of treatment commences. And, the SoC relies on pathologizing research by Dr. Zucker who vehemently opposed the banning of conversion therapy on minors in Ontario when Bill 77 was passed in 2015.⁵²⁰

While OHIP states there are no age minimums for surgeries the SoC sets recommended ages. The SoC only recommends genital surgeries for minors after 16 years of age perhaps because they are very hard to reverse.⁵²¹ The SoC references "medical age of consent" for youth, which very likely reinforces the validity and even existence of age-based markers for consent to treatment in the minds of health care providers.⁵²² For partially reversible interventions like cross sex hormone therapy, 16 again is the recommended age for "medical consent" although the SoC notes that parental consent may not be required.⁵²³ The concern is that practitioners with low-

⁵¹⁹ Kenneth Zucker, "Opinion | Sunday Dialogue: Our Notions of Gender", N Y Times (29 June 2013), online: <<https://www.nytimes.com/2013/06/30/opinion/sunday/sunday-dialogue-our-notions-of-gender.html>>.

⁵²⁰ WPATH 2011 *supra* note at 16; *Affirming Sexual Orientation and Gender Identity Act*, 2015, SO 2015, c. 18 - Bill 77, 24 July 2014 [ASOGIA].

⁵²¹ SoC *supra* note 273 at 18.

⁵²² *Ibid* at 19.

⁵²³ *Ibid* at 19.

level knowledge of trans health, fear of law suits by parents or transphobic or ageist attitudes may rely too heavily on the SoC rather than their own judgement and application of the *HCCA*.

In the past, WPATH had advocated for a three-month period of life experience in the felt gender role prior to starting hormone therapy. This step was developed to establish coping mechanisms for the abovementioned social stressors. The ‘Real Life Experience’ (RLE) requirement has been shown to be especially stressful and frequently dangerous for trans racialized people. By requiring racialized trans people to express a non-normative gender role prior to acquiring any physical changes commensurate with that gender, increased their vulnerability to interpersonal, public and state violence beyond that of cis racialized and white trans counterparts.⁵²⁴ Several sources discussed in Chapter 1 provided evidence that racialized trans people especially Black and Indigenous people experience disproportionate levels of police violence, harassment and profiling.⁵²⁵

Fortunately, there is no longer a prerequisite for an RLE of any length prior to starting hormone therapy. For surgical interventions such as genital surgery and gonadectomy a one-year RLE is still recommended.⁵²⁶ For chest surgery youth are expected to have spent “ample” time in a desired gender role and completed one year of testosterone treatment.⁵²⁷

⁵²⁴ Annelou LC de Vries, Peggy T Cohen-Kettenis & Henriette Delemarre-Van de Waal, *Caring for Transgender Adolescents in BC: Suggested Guidelines: Clinical Management of Gender Dysphoria in Adolescents* (Canadian Rainbow Health Coalition, 2006); Sarkisova, *supra* note 329; Rachel Giblon & Greta R Bauer, “Health care availability, quality, and unmet need: a comparison of transgender and cisgender residents of Ontario, Canada” (2017) 17 BMC Health Serv Res 283; on the murder of trans woman Chevranna Abdi by police in Hamilton see Robyn Maynard, *Policing Black Lives: State Violence in Canada from Slavery to the Present* (Fernwood Publishing, 2017).

⁵²⁵ In addition, see F. Cader and B.A. Amofah, “Why do discussions about carding ignore the experiences of women and trans people?” NOW Magazine, Toronto, 28-Nov-2016.

⁵²⁶ Coleman et al, *supra* note 273 at 21.

⁵²⁷ *Ibid.*

In addition to gender affirming physical modification, however, the SoC emphasizes the role mental health professionals working with transgender youth have to fulfill and which concerns should be canvassed as part of a holistic treatment plan.⁵²⁸ There are two factors to note here: first, that North American and European psychiatry, psychology and endocrinology form the foundation of the research the SoC relies on, and second, that the research is based primarily on the white youth who are referred to gender clinics in urban areas accompanied by their parents.⁵²⁹ As we will see below, these whitening factors shape the *DSM* and the SoC, which claims to be universally applicable.⁵³⁰ Authors of both are overwhelmingly white, male cis and North American and thus both documents define transness in white/Western terms.⁵³¹ The SoC v7 makes a brief acknowledgement that “much of the recorded clinical experiences and knowledge in this area of health is derived from North American and Western European sources” taking the analysis no further.⁵³² The SoC v7 also explicitly tries to depathologize GD through statements which are not followed through in the clinical guidelines. Because both documents are endorsed by OHIP they have the greatest impact on trans racialized youth health autonomy.

Overall, while the SoC recognizes the dangers of abuse that can follow from withholding GA treatments from youth, significant hurdles are maintained through reliance upon “colour-blind” psychiatric diagnostic criteria, age thresholds, time limits and mental health assessments even for HRT. Furthermore, a contradiction exists between declaring that there is nothing inherently

⁵²⁸ *Ibid* at 13–14.

⁵²⁹ Interview with Dr. Cary’s Massarella, (August, 2016); Interview with Dr. Joey Bonifacio, Department of Pediatrics, St Michael’s Hospital and the Hospital for Sick Children, (July, 2016); Interview with Dr. Miriam Kaufman, Paediatrician, Transgender Youth Clinic, the Hospital for Sick Children, (2017); Pyne 2018, *supra* note 35.

⁵³⁰ Coleman et al, *supra* note 273 at 3–4.

⁵³¹ Caplan & Cosgrove, *supra* note 137.

⁵³² See “Global Applicability of the Standards of Care” Coleman et al, *supra* note 273 at 3–4.

wrong with being trans and that conversion therapy is unethical, but then adopting norms entrenched in its white/Western cisgender psychiatric research foundations.⁵³³ As I will discuss below, other agencies such as the Sherbourne Health Centre have collaborated with community members to create a more autonomy enhancing approach based in primary care. Yet OHIP coverage relies on adherence to the SoC requirements in approvals for subsidized surgeries with its built-in coercive pathology, and gatekeeping role for physicians especially psychiatrists, thus use of the SoC continue to erode trans racialized youth's autonomy.⁵³⁴

Health Insurance Act Reg.^{552 535}

Access to Healthcare and Health Insurance Models

As discussed in my research portrait of trans health in Chapter 1, Namaste's 1995 study found that transsexuals and transgender people face a multitude of interpersonal and systemic barriers in Ontario health services.⁵³⁶ They lacked health information, health rights information, safe access to hormones, were mistreated by hospital staff, were denied entry to traditional alcohol and drug rehabilitation programs and were refused access to shelters designated for youth, women and the homeless.⁵³⁷ The very conditions necessary for autonomy in health care decision

⁵³³ Nicholas Matte, Aaron H Devor & Theresa Vladicka, "Nomenclature in the World Professional Association for Transgender Health's Standards of Care: Background and Recommendations" (2009) 11:1 Int J Transgenderism 42.

⁵³⁴ MHLTC SRS, *supra* note 274.

⁵³⁵ Health Insurance Act, *supra* note 8, Reg. 552, *supra* note 8.

⁵³⁶ Namaste 2000, *supra* note 75; for national coverage of GA treatments see "Publicly Funded Transition related Medical Care in Canada" 2015 CPATH and United Food and Commercial Workers Canada <<http://www.cpath.ca/wp-content/uploads/2016/02/Publicly-Funded-Transition-Related-Medical-Care-in-Canada-Executive-Summary.pdf>>. The infographic contains information accurate to April 21, 2015 for BC and Canada, and to September 11, 2015 for the rest of Canada.

⁵³⁷ Namaste documented lack of safe and supervised access to hormones at 166-169, mistreatment by hospital staff at 157-169, denial of entry to traditional alcohol and drug rehabilitation programs at 184, refusal of access to shelters designated for youth at 174, women and the homeless at 177, 182-183 and 189 in Namaste 2000 *supra* note 75.

making were attacked by government institutions, policies and attitudes of providers. And yet subsidized health services are critical for the bulk of trans people who do not have employment related health benefits, due to being disproportionately under or unemployed.⁵³⁸ Poverty is racialized and gendered and employment access is shaped by English language proficiency and citizenship status which puts many trans racialized youth at a disadvantage.

While OHIP adopted the superficially and recently trans-affirming SoC when developing policies and regulations on insurance coverage for transition, related primary care coverage has a checkered history and is still not comprehensive or easily accessible.⁵³⁹ Since 1978 Ontario had covered “sex reassignment” surgery (SRS) meaning, top surgery for trans masculine people and bottom surgeries for both trans men and trans women under Regulation 552 of the *Health Insurance Act* and the Schedule of Benefits.⁵⁴⁰ Unlike many other insured surgical services, to be eligible for SRS subsidies a person had to complete the psychiatric assessment program at the GIC and be recommended for surgery by the CAMH GIC and the Ministry itself.

In 1998 soon after the *HCCA* came into effect, the Ministry under a Mike Harris government, delisted SRS saying the move was part of broad cost cutting measures necessary to keep the health insurance system viable. Yet, due to the GIC’s high rejection rate for trans applicants, only about six people were recommended for surgery each year. In sum the cost of SRS to

⁵³⁸ *Brodeur v Ontario (Health and Long-Term Care)*, 2013 HRT0 1229 (Canlii) at para 25 -27, where two applicants alleged discrimination on the basis of sex due to OHIP refusing to cover them for voice therapy, breast augmentation and laser hair removal. In *Brodeur*, the Tribunal cited *Auton (Guardian ad litem of v British Columbia (Attorney General)* 2004 SCC 78 CanLii at para 35 and *Shulman v College of Audiologists and Speech Language Pathologists of Ontario*, [2001] OJ No.5057 at para 2 to show that provincial health insurance schemes need not cover everything that is medically necessary.

⁵³⁹ MHLTC SRS, *supra* note 274.

⁵⁴⁰ <https://www.ontario.ca/laws/regulation/900552>

Ontario was a mere \$123,891.83 out of the \$30 billion annual health care budget suggesting that gender-affirming care was less of a budgetary issue and more of a political maneuver.

Four trans people who had almost completed the real-life experience of the GID program challenged the Ministry's delisting of SRS in *Hogan*.⁵⁴¹ The majority for the Tribunal found discrimination on the grounds of sex and disability for three out of four claimants and awarded them amounts between \$20-35,000 to reimburse them for the surgeries the province would have covered prior to the date of delisting. The majority's decision relied on ss. 11 of the OHRC, which refers to adverse discrimination or indirect discrimination.⁵⁴²

Several major changes in health insurance coverage have taken place since *Hogan*.⁵⁴³ The same gender affirming surgeries were re-listed as insurable in 2008. Prior to 2015, Ontario required that all subsidized gender affirming surgeries had to be recommended by the Gender Identity Clinic at CAMH (run entirely by cisgendered staff).⁵⁴⁴ In November 2015, Regulation 552 was amended again to extend the surgical referral role to any medical professional, acting in accordance with the SoC.⁵⁴⁵ This loosening of the CAMH GIC's gatekeeping monopoly was necessary because of the extreme hardships caused by their wait lists, delays and rejection rate.⁵⁴⁶ At least one human rights complaint had been filed over the wait times at CAMH and SBT cases

⁵⁴¹ *Hogan v Ontario (Health and Long-Term Care)*, 2006 HRTO 32 (available on <http://canlii.ca/t/1r791>).

⁵⁴² Ontario Human Rights Code, *supra* note 4.

⁵⁴³ *Hogan supra* note 543.

⁵⁴⁴ Interview with Jordan Zaitzow (April 2016) and interview with Kusha Dadui, Coordinator of TransFusion Crew, and Gender Journeys at Supporting our Youth (SOY) at the Sherbourne Health Centre (May 21, 2017).

⁵⁴⁵ *O Reg 291/17*, General, amending Reg 552 of R.R.O. 1990.

⁵⁴⁶ These cases illustrate the hardships faced by trans people: *AS v Ontario (Health Insurance Plan)*, 2006 ON HSARB (available on <http://canlii.ca/t/2c79b>); *JV v Ontario (Health Insurance Plan)*, 2009 ON HSARB (available on <http://canlii.ca/t/2bztj>); *JJC v Ontario (Health Insurance Plan)*, 2011 ON HSARB (available on <http://canlii.ca/t/fpfv8>); *BJP v Ontario (Health Insurance Plan)*, 2015 ON HSARB (available on <http://canlii.ca/t/glf8j>); *CM v Ontario (Health Insurance Plan)*, 2015 ON HSARB (available on <http://canlii.ca/t/gg37k>); *RKN v Ontario (Health Insurance Plan)*, 2015 ON HSARB (available on <http://canlii.ca/t/gk2w4>).

mention the unnecessary hardship caused by having to travel to the Toronto clinic when primary health care could be provided by local doctors.⁵⁴⁷ Currently, there is one letter of reference required from mental health professionals for most procedures and two letters required for genital surgeries.⁵⁴⁸ Trans people in major urban centres will likely have an easier time getting referral letters though letters are not guaranteed due to barriers such as income, English language proficiency, occupation, age, mobility and race/ethnicity.⁵⁴⁹

What has remained the same? The new regulations in Ontario continue to require that surgical referrals need to align with the SoC which will create barriers for trans racialized youth who may not be seen as stable due to lack of housing, income, family support, or having other mental illness diagnoses caused by the impacts of racism. Furthermore, the general requirement that the MHLTC pre-approve all gender affirming surgeries is an encumbrance not placed on other surgical referrals, which causes delays and leaves room for physician errors.⁵⁵⁰ OHIP coverage is marked by trans misogyny in terms of the number of services deemed unnecessary and therefore not covered for trans women such as laser hair removal, voice and communication training, facial feminization voice therapy.⁵⁵¹ Ontario's new regulations ostensibly cover top surgery for trans women (augmentation mammoplasty). However, service providers find the eligibility

⁵⁴⁷ Hogan, *supra* note 543.

⁵⁴⁸ MHLTC SRS, *supra* note 274.

⁵⁴⁹ Interviews with Kusha Dadui, *supra* note 546, Jordan Zaitzow, *supra* note 546, Kai Cheng Thom (May 19, 2016).

⁵⁵⁰ *ML v Ontario (Health Insurance Plan)* 2017 CanLII 44819 (ON HSARB), <<http://canlii.ca/t/h4qmj>>, when ML's doctor failed to add a mastectomy to his list of surgeries for Ministry pre-approval the Board commented: "It is unfortunate that this Ontario teenager paid privately for a procedure that would have been funded by OHIP, it appears, had the family physician followed the procedure outlined in the Regulation. Moreover, it is ironic, given the change to the Regulation made in March 2016, which was intended to broaden access to referrals for OHIP-funded SRS procedures." at para 34.

⁵⁵¹ *Health Insurance Act*, *supra* note 8; see also Brodeur and accompanying text, *supra* note 540.

criteria impossible to meet.⁵⁵² To obtain a subsidized breast augmentation, trans women in Ontario are required to have taken feminizing hormones for at least one year and have experienced zero breast growth (aplasia). Jordan Zaitzow, a Provincial Trans Health Coordinator at Rainbow Health Ontario, has observed some clinicians try to assist their clients, by being flexible on how they measure "no growth", but OHIP applies the Tanner Stage measurements for secondary sex characteristics to evaluate their eligibility requirements. So far, all referrals Zaitzow has heard of have been rejected.⁵⁵³

In addition, an unsuccessful legal challenge was made over what constitutes a "medical necessity" in the context of trans women and laser hair removal.⁵⁵⁴ Currently, medical necessity is defined by cis gendered standards – i.e. whether cis women who might receive the treatment are publicly funded. However, this logic ignores the fact that their reasons for doing so are purely cosmetic and does not deconstruct what we consider to be cosmetic and the different needs of trans women.⁵⁵⁵

OHIP+: The New Youth Pharma Care Plan

Youth can receive coverage for drugs such as Lupron, estradiol, testosterone and anti-androgens if they are receiving income assistance from Ontario Works or Ontario Disability Support Program, by submitting an Exceptional Access Program form filled out with the support

⁵⁵² See s.17 (b) of *Regulation 552*, *supra* note 8.

⁵⁵³ Email correspondence with Jordan Zaitzow, Rainbow Health Ontario (May 2017); also see *Brodeur*, *supra* note 527 at para. 36.

⁵⁵⁴ *Brodeur ibid* at paras 21-23.

⁵⁵⁵ Samuel Singer, "MARGINALIZING TRANS MEDICAL EXPENSES: LINE-DRAWING EXERCISES IN TAX" (2013) 31:2 Windsor Yearb Access Justice 305.

of their primary care provider if they have one.⁵⁵⁶ In Chapter 5 trans racialized youth share their experiences of attempting to navigate systemic access hurdles. Far fewer youth of colour will access puberty blocking and hormone replacement drugs through the employee health benefits of their parents for several reasons. This is because racialized families are less likely to enjoy employee health benefits due to the precarity of their jobs that lack health benefits.⁵⁵⁷ Racialized youth may not be on social assistance because they live at home. Youth whose parents do not have employment health benefits but who are not themselves on social assistance, i.e., they live at home, fall into the gap that the new OHIP+ program could resolve. Currently Lupron costs \$500.00 a shot making it unobtainable for working class and low-income families and youth since it must be administered daily for 1-3 months.⁵⁵⁸ Youth who are not enrolled full-time in a recognized post-secondary institution could also lose their entitlement to their parent's plan if they are over 18 years according to Green Shield and Great West Life.⁵⁵⁹

The Hospital for Sick Children's Transgender Youth Clinic occasionally encounters patients without any means to pay for drugs and has at least once approached the makers of Lupron successfully for complimentary courses of the drug.⁵⁶⁰ A youth worker at Skylark Youth Services in Toronto also mentioned employing the same approach for a youth whose parents

⁵⁵⁶Interview with Vlad from Sherbourne LGBTQ Health Team. To check Medication Coverage in Ontario see online <<https://www.ontario.ca/page/check-medication-coverage/>>.

⁵⁵⁷ Law Commission of Ontario, *Vulnerable workers and precarious work: final report* (Toronto, Ont.: Law Commission of Ontario, 2013) at 19–25.

⁵⁵⁸ Gill-Peterson 2014, *supra* note 61; Interview with Dr. Miriam Kaufman, the Hospital for Sick Children's Transgender Youth Clinic, (August 3, 2017); Pooja S Gehi & Gabriel Arkles, "Unraveling Injustice: Race and Class Impact of Medicaid Exclusions of Transition-Related Health Care for Transgender People", 4 SEXUALITY RES. & Soc. POL'Y 7, 12 (2007); Prescribing information for Lupron online at https://www.accessdata.fda.gov/drugsatfda_docs/label/2011/020263s0361bl.pdf.

⁵⁵⁹ Pogi, a focus group participant mentioned losing benefits over not having fulltime student status during the Member Checking Session 2017.

⁵⁶⁰ Kaufman, *supra* note 560.

refused to pay for their Lupron.⁵⁶¹ This of course is not an approach to be used consistently but speaks to the resourcefulness of some healthcare providers who are supported by their institutions.

In June 2017 the Liberal government announced a pharma care program to pay for prescription drugs for the province's children and youth.⁵⁶² It remains to be seen what drugs will be covered by the new plan and how pharmacies will respect the decision-making autonomy of youth when they fill their prescriptions. Most recently, in 2018 the PC government announced that children and youth will not receive free pharmaceuticals if they have private coverage through their parents plans.⁵⁶³

The Sherbourne Health Centre Guidelines

This section analyzes the health guidelines for Ontario trans youth as found in the *Sherbourne Health Centre Guidelines and Protocols for Comprehensive Primary Care for Trans Clients [the Guidelines]*.⁵⁶⁴ The Sherbourne Health Centre (SHC) is unique because it is located in a neighbourhood with several other trans community service providers, and has at least one trans doctor, and several trans nurses and trans health care providers on staff.⁵⁶⁵ Rainbow Health

⁵⁶¹ Afi Browne, Skylark Children Youth and Families, Correspondence (2017).

⁵⁶² Kelly Grant, "Five things to know about Ontario's new youth pharma care program", (28 April 2017), online: <<https://www.theglobeandmail.com/news/national/five-things-to-know-about-ontarios-new-youth-pharmacare-program/article34853299/>>.

⁵⁶³ <https://www.ctvnews.ca/canada/ontario-youth-pharmacare-to-no-longer-offer-free-meds-for-those-with-private-coverage-1.3995725>

⁵⁶⁴ Dr Amy Bourns & Sherbourne Health Centre, *Guidelines-and-Protocols-for-Comprehensive-Primary-Care-for-Trans-Clients-2015.pdf* (Rainbow Health Ontario, 2015) [Guidelines]. Other sets of trans health guidelines have been developed in Canada that augment and diverge from the WPATH SOC such as J.L. Feldman & J. Goldberg, *Transgender primary medical care: Suggested Guidelines for Clinicians in British Columbia* (Transgender Health Program, Vancouver Coastal Health, 2006).

⁵⁶⁵ Accurate to March 2016.

Ontario (RHO), a program of Sherbourne Health Centre, shares space in the same building. RHO provides information, training and resources on LGBTQ+ public health across Ontario and has delivered training about the *Guidelines* since 2011. The *Guidelines* provides a useful public health contrast to the clinical psychiatry-led WPATH text.

Consultations were held in 2003 with trans communities who access the SHC.⁵⁶⁶ SHC staff and interested community members met for discussion of needs and concerns. The group also reviewed other protocols. Unlike the SoC, some trans input was incorporated into the protocols.⁵⁶⁷ Trans community knowledge incorporates trans lived realities and health expertise which has been sorely lacking in research on transness, and the creation of protocols for trans health, not to mention general health policy that also affects trans people.⁵⁶⁸ As a result of community input the *Guidelines* reflect a more collaborative and patient-directed approach that recognizes trans community knowledge about health care.⁵⁶⁹

Unlike the SoC, the *Guidelines* relate gender affirming treatments to the provision of primary care as opposed to automatically relegating trans needs to psychiatrists and endocrinologists.⁵⁷⁰ The 2015 edition was also adapted to better suit needs of non-binary clients.⁵⁷¹ The purpose of these guidelines is to expand the number of primary care providers who feel competent to see trans clients by describing routine care practices tested by SHC nurses, nurse practitioners and

⁵⁶⁶ I was unable to find out if racialized people, and racialized youth took part and how outreach was carried out.

⁵⁶⁷ *Guidelines*, *supra* note 566 at 5; Matte et al, *supra* note 535.

⁵⁶⁸ *Ibid* at 2.

⁵⁶⁹ Florence Paré, “Do you know my relationship to the mirror? A perspective article on public policy surrounding informed consent to transition-related surgeries for transgender Quebecers.” (2018) McGill J Law Health.

⁵⁷⁰ *Guidelines*, *supra* note at 2.

⁵⁷¹ *Ibid* at 4, the *Guidelines* describe how non-binary clients can receive hormone therapy without a GD diagnosis under the rubric of harm reduction, or by fast tracking clients well known to providers.

doctors.⁵⁷² This is evident in the *Guideline*'s description of dosages and monitoring for more typical cases of HRT that would enable a trans client to obtain standard care from their family doctor. This kind of precise information for local doctors would prevent an automatic consult with an endocrinologist a process causing delays and likely the need to travel to an urban center, often not possible for a trans racialized youth.⁵⁷³ Another notable practice example from the Guidelines is the refraining from automatic referrals to psychiatrists or CAMH, encouraging family doctors to make the diagnosis of GD listed in the *DSM -V*.⁵⁷⁴ While their public health equity approach to the care of trans clients is a strength of the *Guidelines* the phenomena of racism, classism and ageism as social determinants of health are not explicitly named. Still, inclusion of access to health care tips for Ontario practitioners about navigating provincial drug plans and health insurance policies to assist clients in accessing hormone therapy and writing free support letters to obtain gender accurate identity documents would have a significant benefit for trans racialized youth.⁵⁷⁵ The *Guidelines* include some inaccurate information about consent to treatment law by claiming that there is no specific age of consent in Canada, when like all health related matters, it is a provincial jurisdiction.⁵⁷⁶ They do not define capacity precisely,

⁵⁷² *Ibid* at 5.

⁵⁷³ *Ibid* at 2, 7. For examples of the impact of unwilling or incompetent family doctors on trans youth see 1401-00532 (Re), 2014 where a 25 year old youth from a small town was waiting for referrals to Toronto doctors and deeply depressed as a result of gender dysphoria and transphobia to the point of being disabled and qualified for ODSP; and 2017 ONSBT 4197 (CanLII where the family doctor of a 23 year old trans youth was not comfortable prescribing hormones for them and referred them to a GIC with a long-wait list causing disabling distress; also 1109-07575 (Re), 2013 ONSBT 496 (CanLII), where a 23 year old who was not receiving any gender affirming care because their psychiatrist wanted them to go to a Toronto GIC for a "full diagnosis from a gender specialist" first and they could not afford to travel and stay there.

⁵⁷⁴ *Ibid* at 11.

⁵⁷⁵ *Ibid* at 22-23. Note that since April 2017 nurse practitioners who have completed specific courses can prescribe controlled substances such as testosterone, http://www.health.gov.on.ca/en/news/bulletin/2017/hb_20170419.aspx; an Exceptional Assistance Program request under the Ontario Drug Plan for injectable testosterone is much cheaper and is therefore preferable to clients over transdermal patches which deliver a more stable dose of testosterone, *Guidelines supra* note 566 at 23.

⁵⁷⁶ *Guidelines supra* note 566 at 10.

however they show confidence in primary care providers to make capacity assessments for trans clients just as they would for any other clients, being mindful of cognitive abilities, age, life experience and substance use.⁵⁷⁷

The health care provider's role in assessing a client's eligibility and readiness for HRT creates an inequitable dynamic, with the provider acting as the 'gatekeeper' to treatment. In response to this, the SHC practices the 'informed consent model' for hormone therapy which aligns with the *HCCA*. In this model, the primary care provider focuses on obtaining informed consent as the threshold for the initiation of hormone therapy, with less emphasis on meeting *DSM-V* diagnostic criteria for Gender Dysphoria or requiring a mental health assessment unless significant mental health concerns are identified.⁵⁷⁸ The primary care approach to mental health is more nuanced and intersectional than the SoC's reliance on clinical expertise, due to SHC's reliance on community based knowledge and community based research through research affiliates like TRANSpulse offers methods for a depathologizing way of caring for trans people.⁵⁷⁹ However, as doctors from Ontario youth clinics confirm, this informed consent model works best where youth rely on their parent's health care benefits not on OHIP which require the diagnosis for coverage of surgeries.⁵⁸⁰

The primary care model developed by the SHC in collaboration with trans community members incorporates social determinants of health and public health strategies making it a more effective and autonomy enhancing system for those youth within its catchment area, in contrast to the medical model applied in other sites across Ontario.

⁵⁷⁷ Ibid.

⁵⁷⁸ SoC *supra* note 273 at 5-6.

⁵⁷⁹ *Guidelines supra* note 566 at 13.

⁵⁸⁰ Dr Carys Massarella, *supra* note 161; Dr. Joey Bonifacio, Department of Pediatrics, St. Michael's Hospital and the Hospital for Sick Children, *supra* note 161; Dr. Miriam Kaufman, Paediatrician, Transgender Youth Clinic, the Hospital for Sick Children, *supra* note 161.

Conclusion

This chapter illustrated how taken together, Ontario's expansive health statutes, policies, and insurance programs have not actually expanded access to needed resources for trans racialized youth and have in application intensified their exclusion from autonomous decision making in health care. Legal sources I examined failed to explicitly recognize social determinants of health such as age, race, class, and gender identity that affect access. Since access to non-trans specific health care is racialized, then access to trans specific health care will also be racialized.

The cases that propelled the development of the common law primarily turned on refusal to consent to life-saving treatments on the grounds of religion. With few exceptions, judges imbue decisions about young people's health, whether minors or not, with paternalism. Youth autonomy is seen as undermined only by parents and by religion and not by systemic forces of poverty, racism, citizenship status or cisnormativity. Decisions show that judges determine capacity by evaluating the correctness of a young person's decision especially if there is risk to life or the body is modified significantly.

Courts have not addressed whether trans youth can make life-altering, and as some would argue, life-saving medical decisions about transitioning. These discussions have addressed social transitions or taken place in family courts where the tendency of jurisprudence from lower courts is to ignore or to override the application of the youth's right to consent pursuant to the *HCCA*. And indeed, the Ontario Court of Appeal has yet to rule on this issue head on.

The erosion of gender essentialism has changed faster in statutory law such as human rights codes and vital statistics acts than in the minds of judges where decades of gender essentialism and binary gender have created precedents. Jurisprudence continues to promulgate ontological

myths about binary gender even as decision makers recognize transnormative options for trans legal subjectivity.

Even though the general objectives of the *HCCA* claim to support autonomy and it contains a presumption of capacity for all persons, broad understanding of and compliance with the *HCCA* remains a significant issue for health care providers. These claims remain aspirational because the *HCCA* lacks the regulatory infrastructure required to create conditions that foster autonomy namely: information sharing, redress for findings of incapacity, and non-automatic appointment of family of origin as SDMs, collaborative decision making by youth and trusted advisors, adequate trainings for professionals and regular intersectional public awareness aimed at youth.

The relationship between the *DSM-V*, the SoC and OHIP regulations cements the white/Western bias of diagnostic criteria, into clinical eligibility standards for transgender people, and subsidized health care. This is exacerbated in application by the gatekeeping role assigned by all three texts to physicians, nurses and mental health professionals.

The triple threat structure produces diminished standards for autonomy: the coercive pathology of diagnostic criteria rejects trans racialized youth selfhood; eligibility criteria prevents them from accessing treatments and services, and gatekeeping diminishes the potential for therapeutic honesty. Locally developed guidelines for primary care practitioners address some of these problems in effective ways. I contend that replacing relational autonomy with informed consent is flawed. Informed consent is an individualized process locked in a system that does not adequately inform structurally vulnerable youth of their statutory rights.

Legislators though aware of equity-based principles and progressive legal norms, need to enact education and monitoring into statutes so autonomy conditions can be fostered. This is

critical since advocacy mechanisms were repealed and it seems that youth find internal equity complaint programs and courts inaccessible.

As such, youth experience legal restrictions to their decision-making autonomy due to inadequate health care rights knowledge and protectionist beliefs from their families, health care practitioners, social workers and judges framed as questions about their capacity best interests or through language and application of bureaucratic policy. Furthermore, phenomenological field work data presented in the next chapter, confirm that trans racialized non-minor youth continue to be subjected to arbitrary constraints on their autonomy in health care decision making.

Chapter 5: Transcendent Bodies

Introduction

The question at the heart of this research project is: How do trans racialized youth experience autonomy in health care decision making? To lay the groundwork for this, in Chapter 2 I discussed a relational version of autonomy and distinguished it from the concept of agency. I theorized that autonomy is the ability to act in a manner congruent with one's values, long-term individual and collective interests, and in consideration of different types of personal, social and political relationships.⁵⁸¹ I developed a list of six factors conducive to autonomous decision-making for trans racialized youth. As Chapter 4 explained, Ontario's health care consent statute presumes that everyone can capably make their own health care decisions unless proven otherwise.⁵⁸² In addition, I considered the meaning of legal capacity to make health care decisions and the process of informed consent or refusal. Moreover, we saw how judge's written decisions act as a type of representation of the litigants' experience and identity. Most judicial representations reproduce and affirm medically-constituted notions of the essence of transness that ultimately confine trans people to heterosexual binary narratives and fail to validate the health consent rights of minors. Recall from Chapter 1 that critical trans scholars have long critiqued these legal and medically-produced narratives as transnormative.

⁵⁸¹ My definition is developed from the works of Roberts 1996, *supra* note 183, Roberts 1997, *supra* note 157, Sherwin 1998, *supra* note 157, Jennifer Nedelsky 1989, *supra* note 157, Nedelsky 1993, *supra* note, 164, Meyers 1989, and 2005 *supra* note 167, Moya Bailey & Whitney Peoples, "Articulating Black Feminist Health Science Studies" (2017) 3:2 Catalyst: Feminism, Theory, Technoscience, online: <<http://catalystjournal.org/ojs/index.php/catalyst/article/view/120>> and Dean Spade, *Normal Life: Administrative Violence, Critical Trans Politics, and the Limits of Law* (Duke University Press, 2015).

⁵⁸² HCCA *supra* note 11.

Despite the current state of Ontario law where capacity, not age, is the crucial factor for decision making, I have argued that racialized trans youth are still prevented from making health care decisions autonomously by the attitudes of judges, legislators, health care practitioners, and the barriers embedded in officially endorsed clinical policy documents. Integrating my earlier discussion of theoretical concepts of structural vulnerability, intersectionality, selfhood, relational autonomy and the analytical tool of disidentification theory I now present my focus group results organized thematically. I then discuss participants' responses to the barriers in health care as: autonomy-enhancing, protective/agentive, and a mix of autonomy-enhancing and agentive.

Results

The following results from my focus group with four trans racialized youth are organized under two major themes: a) structural and systemic barriers and b) interpersonal, professional and organizational barriers. Photographs were analysed using the rubric in Appendix 3 with a modified typology of gazes.⁵⁸³ Interview transcripts were analysed using thematic network analysis.⁵⁸⁴

Structural and Systemic Barriers

⁵⁸³ Lutz and Collins, *supra* note 327.

⁵⁸⁴ Attride-Stirling, *supra* note 326.

Within this first major theme, participants described experiences relating to five structural areas affecting autonomous decision-making: financial barriers, legal barriers, undermining consent, gatekeeping, and the institutional nature of care.

Financial Barriers

Participants came from various economic backgrounds and had different income levels based on whether they received financial support from their parents. This impacted their access to health care. The major financial barriers they noted were the cost of pharmaceuticals, doctor's letters, ambulance fees, name change fees, binders, canes, and knee braces pointing to gaps in Ontario's universal health care coverage. Prior to 2018, pharmaceuticals, including cross-sex hormones or puberty-blockers were not covered unless one was an Ontario Works or Ontario Disability Support Program recipient.⁵⁸⁵ According to participants, the coverage for gender-affirming treatments under their parents' employee benefits plans was limited and their access to the benefits was controlled by their parents, therefore not confidential. There were no sliding scales for drugs or doctors' services that were not covered by OHIP. Three participants were unable to benefit from one-on-one mental health services from psychotherapists⁵⁸⁶ or psychologists relying on the OHIP covered services provided by social workers and psychiatrists. This comment reveals Pogi's (they/them) frustration with the interplay between private insurance and ODSP drug coverages both requiring medical documentation:

And then I'm being penalized for being able to work because they don't believe I'm disabled, but it's like nothing, it's contract work. I stopped taking T as well, because it

⁵⁸⁵ As discussed in Chapter 4, by 2018 most pharmaceuticals were covered for youth 25 years of age and under with the introduction of the OHIP+ Youth Pharmacare Plan.

⁵⁸⁶ Gitanjali Lena, ed., Transcript of Focus Group (April 22, 2017) [Day 1]

was costing me too much. It's frustrating because I have to make money to survive but by doing that I can't prove I'm disabled...So I live with my mom, and I was getting her benefits before because I was in school and then I was bipolar, so I was getting benefits because I was bipolar, but then the insurance committee decided to challenge that. So I had to get a bunch forms, a psychiatrist to prove full time incapacitation. But I can't because the doctor I'm seeing doesn't think I have bipolar, so I don't have benefits and I can't apply for ODSP and then I don't even know...and then he's like, lithium is the cheaper one...if I don't have bipolar why do I need medication?

Unlike service providers with lived experience of seeking gender-affirming treatments, participants' doctors appeared uninformed about the costs of drugs, or the ways to access drugs through the Exceptional Access Program (EAP), drug plans and benefit schemes for youth who had no private insurance.⁵⁸⁷ Sakura River (they/them) who was emancipated from the age of 16 described their challenges thusly:

Yeah, I don't have coverage from work, I don't have coverage from family matters, I don't have that coverage like other people might. And other people might have like, family, who helps them get the hormones they want, helps them have things to help their identity, my family was the complete opposite of that.⁵⁸⁸

This passage shows how financial barriers that work against youth with inadequate family support exacerbated their specific situation, thus further undermining their ability to make autonomous decisions in contrast to Participant #4 who lived at home and had some financial support or Pogi whose parents were able to share private insurance benefits with them for a time. Financial barriers to health care caused the participants a great deal of stress and increased the pressure to make agentic choices to avoid health care.⁵⁸⁹

⁵⁸⁷ *Ibid*; Gitanjali Lena, Notes from Focus Group (April 29, 2017) [Day 2 Notes].

⁵⁸⁸ Day 1, *supra* note 588.

⁵⁸⁹ For another supporting quote from see Sakura River below in "Avoidance of Medical Care" at 177.

Legal Barriers

Participants described legal barriers arising from the regulation of gender through identity documentation, and the inadequate provision of information about and application of health consent law. Participant #4 said that requirements “like having gender markers on identification when in essentially every instance they aren’t needed” created a barrier.⁵⁹⁰

None of the participants had official identification with their chosen name or gender markers.⁵⁹¹ Furthermore, one participant reported that they could not afford to change their identification documents to reflect current names and sex designations to reflect lived gender such as, passports and birth certificates. For Sakura River, the major obstacle was being unable to access a legally required birth certificate from their country of birth. They recalled:

I have like my legal documents for Canada, I don’t personally own it, my mum has it...It’s very hard to get those, because she won’t let me have them...She doesn’t want me to change my name. She is refusing to let me change my name on legal documents as she’s like keeping them.⁵⁹²

This passage provides one example of how legal requirements for naturalized citizens and parental control combine to prevent autonomous behaviour for emancipated youth.

Two participants recounted experiences of being misgendered upon presenting their OHIP card to service providers.⁵⁹³ An MRI technician misgendered Participant #4 this way: “the person was gendering me using like he/him pronouns, and then like I gave them my health card and they

⁵⁹⁰ Participant #4, Pre-Focus Group Survey (April 22, 2017).

⁵⁹¹ Gitanjali Lena, Notes from Focus Group (April 22, 2017) [Day 1 Notes].

⁵⁹² Ibid.

⁵⁹³ In 2017 Ontario enacted a policy removing the sex designation from OHIP cards. The focus group met prior to that policy intervention.

were like, ‘OH! You’re a girl!’ and I was just like, fuck this.” Sakura River shared another example of insistence on legal names: “Every time I have to use health care, I tell them of my identity and most just decide that I am a female and my legal name is the name they will use. It creates a huge sense of incompetence in doctors as well and does not help my issues.”⁵⁹⁴

Sakura River’s photograph “UNH Invoice”⁵⁹⁵ captures their frustration with structural barriers. It shows a torn Fact Sheet about changing one’s name on official documentation, and an invoice from the University Health Network for an ambulance half-buried in a muddy puddle strewn with cigarette butts. In my interpretation, this photograph and their quotes demonstrate the delegitimizing power of regulatory documents and how difficult it can be to transition legally. Sakura River also commented that the University Health Network was unwilling to reconsider invoicing them for an ambulance fee despite their efforts to have the fee waived for inability to pay.

Undermining Consent

Informed consent is central to the *HCCA*, however, results show that in application it was undermined. The main tactics identified that contravened *HCCA* provisions and professional regulations on informed consent were: inadequate information, coercion, breaches of confidentiality, and failure to apply the legal presumption of capacity. Results suggest health care providers deployed these tactics more often when the participants were under 18 years old.⁵⁹⁶

⁵⁹⁴ Day 1, *supra* note 588.

⁵⁹⁵ Sakura River, *UHN Invoice* (April 2017).

⁵⁹⁶ Supporting quotes from Participant #4 below at 148, 149 and 150; from Pogi below at 153-154; and from Sakura River below at 149.

Lack of access to health rights information and health related legal remedies created a health rights vacuum for the participants. None of the participants was aware of their statutory rights with respect to consent to treatment in health care. On the first day of the focus group I had asked them questions to assess their legal knowledge pertaining to making health care decisions. Participants had never heard of the *HCCA*. They were unaware of their formal legal rights as youth and rights they possessed as minors under the *HCCA*.⁵⁹⁷ They had never heard of the Consent and Capacity Board and did not know that findings of capacity could be challenged at that tribunal.⁵⁹⁸ Participants had not talked to lawyers or paralegals or community legal workers about health care rights or problems.⁵⁹⁹ They had not encountered legal information about their rights in health care settings or online. In contrast to the community knowledge they accessed about treatments and providers, community knowledge circles such as friends and online groups had shared no information about health care statutes or legal rights.⁶⁰⁰ They were unaware that legal information could help them access their health needs, and of how to go about finding legal information.⁶⁰¹

Before they reached the age of majority, they all disclosed that their parents made their health decisions. During the discussion they disclosed that they did not want their family members to make health care choices for them if they were found incapable. They were not aware that they could interrupt the automatic SDM hierarchy.⁶⁰² Participants reported that health care providers

⁵⁹⁷ Day 1 notes, *supra* note 588.

⁵⁹⁸ *Ibid.*

⁵⁹⁹ Day 1 notes, *supra* note 593.

⁶⁰⁰ *Ibid.*

⁶⁰¹ Gitanjali Lena ed., *Member Checking Session* (August 30, 2017) [MC].

⁶⁰² Day 1 notes, *supra* note 593.

had not informed participants that if they had any problem with family members acting as SDMs participants could challenge decisions or ask for a new SDM to be appointed.

Participants who lived with their parents as minors and young adults expressed the most frustration over doctors' non-consensual involvement of parents in the decision-making processes.⁶⁰³ Participant#4 stated:

As I continue to share residence with my parents my mother in particular has always tried to make particular decisions around my health for me without my full understanding or consent if at all. In my adult years I've tried to give her less space to take up regarding my health, but she still often ends up taking the lead in those conversations.⁶⁰⁴

Further evidence of breaches of confidentiality was shared by Sakura River said their family doctor consulted their mother without asking for their consent. "My mum, at the time she went to the same doctor as me, so in that time the doctor started listening to her side of the story about how I was too confused to know if I was trans and the doctor stopped believing what I was saying."⁶⁰⁵ The consequences of such breaches were serious for Sakura River, "My mum took me off her healthcare plan when I was 13, because I was trans and talked about mental health."⁶⁰⁶

Health care providers sometimes allowed caregivers to exert further control over decision making when they accompany minors or young adults to their doctor's appointments. Two other participants described this experience. At one point, Participant #4 said, "so I go over, and my

⁶⁰³ For additional supporting quote see Participant #4 below at 149.

⁶⁰⁴ MC, *supra* note 603.

⁶⁰⁵ Gitanjali Lena, ed., Transcript of Focus Group (April 29, 2017) [Day 2].

⁶⁰⁶ Ibid.

doctor of course misgenders me, ‘cause like I’m not having a conversation with her about this stuff, especially since like, my mom is usually in the room when I go to the doctor’s office.”⁶⁰⁷

Pogi described how their parents took the lead in all health care discussions, and from a young age they never remember consent being explained to them, it was just assumed by doctors after talking to their parents.⁶⁰⁸

Two photographs evoked this frustration. Pogi’s photograph, “Think before you scream”, shows a person with long curly hair and glasses sitting in a forest in front of a wire fence.⁶⁰⁹ In the background is what looks like a high school sports field. The photograph is black and white except for a bright blue loud speaker that the subject holds away from their mouth. Pogi described the loud speaker as a symbol of urgent communication.⁶¹⁰

Participant #4’s photograph, “The Ground is a long way down, but there is more than one way to be grounded” was taken in response to prompts 1, 3, and 4 (Appendix);⁶¹¹ They used a downward camera angle to force the viewer’s gaze downwards, literally putting the viewer in their shoes. They incorporated a lot of empty space in the foreground of the frame, describing themselves in relation to health care providers as their blackness and their transness being invisible, while their access needs are highly visible but misunderstood. This participant wanted the viewer to be unsure whether the turquoise fish-scale patterned object that points downward to their feet, parallel to their front body is a stick or a cane.⁶¹² The participant wanted to portray the discomfort of health care providers with trans racialized bodies and the negative impact of this

⁶⁰⁷ Ibid.

⁶⁰⁸ Pogi, Pre-Focus Group Survey, (April 22, 2017).

⁶⁰⁹ Pogi, *Think Before You Scream* (April 2017).

⁶¹⁰ Day 2, *supra* note 607.

⁶¹¹ Participant #4, *The Ground is a long way down but there is more than one way to be grounded* (April 2017) [Grounded]; See photography prompts for participants Appendix 2.

⁶¹² Day 2, *supra* note 607.

discomfort on the iterative communication process so critical for decision-making autonomy. Participant #4 said, “Yes, when I was younger there were many conversations about mental health and cognition that were had with my parents rather than including me. I was started on medication without consent, although I refused to take it anyways, and made to be monitored by [sic] teachers via check-ins at my schools.”⁶¹³ They explained how as a child and a teenager, doctors spoke almost exclusively to their parents, and this discouraged them from learning how to communicate with doctors.⁶¹⁴ This photograph and quote demonstrate how doctors, parents and teachers breached confidentiality failed to build trust, communicate information and support autonomous decision making for this person as a minor.

One participant described an experience where a service provider practiced informed consent. Sakura River mentioned two high school social workers who supported their autonomy when they were hospitalized. The social worker asked Sakura River if there was anyone they wanted to be contacted; Sakura River did not want their mother to be notified. The social worker respected their wishes by contacting their cousin who was their main support person. Sakura River described the impact of feeling listened to and cared about in the following way:

She understood that I was not close to my family and she knew not to call them. She knew that and respected that fact so greatly. She was the first one to fully understand it I guess you could say. I felt like super cared for at that time, when I needed it most. Which was like the best ever, because she was just always there. And hospitals never did the same, my own mom never did the same.⁶¹⁵

During our initial discussions on the first day of the focus group about participants’ understanding of consent to treatment practices, Participant #4 said, “In my experience, consent

⁶¹³ Day 1, *supra* note 588.

⁶¹⁴ Ibid.

⁶¹⁵ Day 1, *supra* note 588.

hasn't been made something explicit in medical spaces (specifically from service providers) but is often instead implied.”⁶¹⁶ Participant #1 said they thought that there was an age threshold for receiving cross sex hormone therapy. Pogi thought there were age thresholds for surgery because they had been given consent forms at the beginning of surgery approval processes with the ages of 17 and 18 on them.⁶¹⁷ One participant had heard of “*DSM* criteria”.⁶¹⁸ None of the participants knew the name of the *HCCA*, or were aware of consent, capacity or substitute decision maker hierarchy provisions.⁶¹⁹

As laid out in Chapter 4 another way that autonomous decision making is undermined is through inadequate provision of accessible information about the *HCCA*. All of the participants described a total lack of information sharing about their legal rights as minors when interacting with health care providers and institutions. Pogi reflected on how knowledge of their rights might have changed their experience at the CAMH GIC:

I don't know what would have happened if I was more honest and less rehearsed at the GIC. If I researched more into and took more initiative into asking what I was looking for and being more aware of my rights and the GIC's jurisdiction, if I was less emotional and more practical.⁶²⁰

Pogi had been hospitalized at Sunnyside for bipolarity as a minor. Pogi said they were not informed of the incapacity finding or told how to challenge that finding. This is troubling, recalling from the previous chapter that the requirements for rights advice for incapable people in the psychiatric context are more robust than in non-psychiatric findings of incapacity although

⁶¹⁶ Ibid.

⁶¹⁷ Ibid.

⁶¹⁸ MC, *supra* note 603.

⁶¹⁹ Day 1, *supra* note 588; Day 2 *supra* note 607; Gitanjali Lena, *Member Checking Session Notes* (August 30, 2017) [MC Notes].

⁶²⁰ MC, *supra* note 603.

not for minors. The doctor chose an SDM from the prescribed *HCCA* list but Pogi was not informed of how this process worked. The doctor did not tell Pogi that they could ask for a different SDM. Pogi was unaware that the SDM had to follow any prior capable wishes about treatment Pogi had made at the age of 16. Pogi said that between the ages of 12-16, “I didn’t even know I had a say in health decisions. I was taught that I was a minor, and it would be doctors and parents discussing what to do then explaining what they were going to do.”⁶²¹

The improper resolution of capacity issues was also cited as a reason for inadequate gender-affirming care. Pogi, Sakura River and Participant #1 were all initially found incapable to decide to take cross sex hormone therapy as minors by family doctors in private practice. Participant #1 for example, did not want to disclose their significant anxiety due to numerous experiences of being found incapable simply for having mental health issues and being a minor.⁶²² They did not want to delay starting feminizing hormones so they eventually chose to temporarily take unprescribed hormones by taking a friend’s birth control pill.⁶²³ They explained that they had not been able to find a doctor or nurse who they could work with because so far, at the age of 18, several health care providers told them they were not old enough to make this decision on their own.⁶²⁴

At another time a health care provider who acted non-consensually in an emergency, placed a youth in a difficult financial situation. Sakura River depicts this situation in their photograph, “UHN Invoice”. They staged this photo by crumpling up the invoice for an ambulance that was sent to their home against their wishes. The invoice lies in a muddy puddle with a pen and half of

⁶²¹ Ibid.

⁶²² Day 1 notes, *supra* note 588.

⁶²³ Day 1 notes, *supra* note 593.

⁶²⁴ Ibid.

a cigarette. Sakura River had spoken to a Telehealth nurse about an undisclosed health issue. The nurse thought they had to send an ambulance, despite the fact that Sakura River insisted they did not want an ambulance. Their main reason for refusing the ambulance was the prohibitive cost of ambulance service. Sakura River received many notices to pay this invoice and eventually the fee went to a collection agency.⁶²⁵ Sakura River used their agency to attempt to refuse the ambulance to avoid the fee despite the fact that it was in their best interests to take the ambulance. They eventually took the ambulance because they were told they would be charged regardless. They placed the capped pen and the cigarette butts in the photograph to symbolize their blocked capability to act autonomously.⁶²⁶

All the participants lacked formal opportunities to practice autonomous decision making as they approached the age of majority. This was heightened for two youth whose families were very engaged in their health care as minors. Pogi had experienced parental control over their health decisions up to age 16 and felt suddenly unprepared when doctors began asking their parents to leave the room. Pogi explained it this way:

Yeah, it's weird because like something happens after 16 where the doctors like ask your parents to leave the room. And it's like what? Doctors talk to you directly and ask what I think. I also noticed soon after turning 18 and all up until 21, health care staff seemed to reinforce that I was an adult now, and 'it's your choice, but I...' kind of statements. It was noticeable over time, like I felt and still do, like I'm in autopilot with my health. It's like all of sudden I have this autonomy over my body that I've never practiced asserting, or even understanding what that meant.⁶²⁷

The ways that health care providers undermine autonomous decision making are amplified by the gatekeeping role that health law and policy assign to these professionals. This

⁶²⁵ Day 2, *supra* note 607.

⁶²⁶ Day 2, *supra* note 14.

⁶²⁷ MC, *supra* note 603.

combination negatively impacts a trans racialized youth's self-image, and as participants describe, forces them to engage in agentic strategies such as performance, avoidance of medical care and hiding.

Gatekeeping

As shown through analysis of authoritative texts in Chapter 4, health care providers perform gatekeeping functions by making diagnoses, and approving trans people for gender-affirming treatments. Participants named other gatekeeping actions such as selecting which treatments to propose, sharing medical and legal information, prescribing hormones, and making referrals to specialists. In addition, the participants felt like they had to say yes to whatever the doctor wanted simply to get the diagnosis. Three participants described psychiatrists as having the most direct gatekeeping power because of their power to diagnose Gender Dysphoria. As Pogi complained: "Psychiatrists don't know anything. You spent 12 years, and this is what you got? You have so much power! From insurance, to benefits, letters for id docs, all that trickles down and service providers and judges will take whatever you say here..."⁶²⁸

Participant #4 recognized that: "...for some people doing diagnosis based is really important, it's like necessary. To be able to access different services, to get things subsidized. And like I think some service providers will sprinkle language around willy nilly."⁶²⁹ The health care professional's gatekeeping role to diagnose and provide evidence in the context of disability income support meant that, in Participant #4's own words:

⁶²⁸ Day 2, *supra* note 607.

⁶²⁹ Ibid.

I did and still continue to avoid getting diagnosed for things that are necessary, like accessing ODSP for example; but even when in a medical space I still have a difficult time trying to convey any issues I'm having, leading to me being, underdiagnosed, made to wait, disbelieved, or ignored.⁶³⁰

Paternalism manifested through gatekeeping and capacity assessment when Pogi tried to find a doctor who would prescribe them testosterone. Pogi's family doctor considered them too young and would not prescribe. Then their doctor tried to put them on the CAMH GIC waitlist in 2014. They were waitlisted for the GID youth clinic at CAMH in 2015, and eventually was called for an appointment in 2016. By this time Pogi said, "... I was referred to a St Mike's clinic nurse through Pieces to Pathways who was reputedly trans-competent. Three weeks after that I started taking testosterone."⁶³¹ This quote shows that Pogi received more timely access to care from peer trans youth workers who run Pieces to Pathways, a substance use program for LGBTTTQ+ youth who were better at facilitating access to hormones for low-income youth and emancipated trans youth. This access was facilitated in part, by the provincial by-law change in March 2017 that allowed nurses to prescribe controlled substances like testosterone, after taking some additional training thus reducing the reliance on doctors.⁶³²

Referrals from family doctors were needed to get appointments with specialists, however participants struggled just securing or maintaining a relationship with a family doctor for primary care. Doctors are also required to sign approval forms for treatment. Participant #4 said they were seeing their family doctor, "but only really for a medical referral". After months of searching for a doctor who was seeing new clients, getting on waitlists at recommended clinics,

⁶³⁰ Ibid.

⁶³¹ For evidence of the contrasting actions of the doctors and CAMH GIC administrators see Pogi's quote below at 168-69.

⁶³² NPs prescribing controlled substances, Q & A Regulations and bylaws, website of the College of Nurses of Ontario, <http://www.cno.org/en/trending-topics/nps-and-prescribing-controlled-substances/qas-proposed-regulations-and-by-law-changes/>

“talking to different representatives who would give me different information,” Pogi recalls how “desperate I was to start HRT”. They said after trying to access HRT “that was incredibly charged with emotional energy, I felt drained and depressed with each phone call.” Finally, being refused testosterone at the CAMH GIC, Pogi said: “I was confused to what the point of the GIC was and why my doctor had referred me here if she could have prescribed me HRT. The GIC is busy, if I had [lot] schedule to see these people consistently before getting a referral that would take months on top of the medication.”⁶³³

Furthermore, participants named three health categories explicitly used to block access to gender-affirming care: disability, body weight and mental health. The insurance company that administered Pogi’s parent’s employee benefits program wanted proof of disability to cover them for hormones. Pogi was reluctant to frame themselves as disabled for being trans and bipolar. Furthermore, proving disability would have required even more meetings with doctors, so instead they chose to pay for their hormone therapy out of pocket, as he was not on OW or ODSP. Through a discussion of their photograph, “Reading between the Signs”,⁶³⁴ Pogi shared that their bi-polarity diagnosis became a gatekeeping issue to be either hidden or presented as appropriately managed before they were seen as stable enough to access gender affirming treatments, a policy which matches the requirements in the *DSM-V* and SoC v7. About being assessed at CAMH GIC Pogi said: “So like I had to be distressed about how I was unable to physically transition but not so distressed I was mentally unstable.”

Doctor’s preoccupation with weight frequently arose as a type of gatekeeping for Participant #4. Participant #4 believed that doctors used their size as a way to dismiss other health needs.

⁶³³ MC, *supra* note 603.

⁶³⁴ Pogi, Reading Between the Signs (April 2017).

They had been told by doctors, “you have to lose ten pounds before I’m gonna do any other treatments.”⁶³⁵ Participant #4 was motivated to address this experience visually by taking pictures of their belly. They said, “weight and being plus size doesn’t need to be an access to health care issue but it is,” and:

...you enter the room and it’s like, ‘Well you could lose some weight’ and I think that’s a particular experience of doctors doing that to either women or people perceived as women...and that’s a gatekeeping method for doctors.⁶³⁶

Results demonstrated the gatekeeping role law and health policy assigns to doctors in particular. We now look at what participants said about the health care system overall.

Institutionalization of Care

Despite the closure of the CAMH clinic and the passage of legislation banning the use of conversion therapy on minors, two participants expressed a lingering fear of retribution if opinions about doctors or institutions such as CAMH were made public. Pogi talked about not wanting to vilify CAMH through their photo, “Building on Health Care”, as they had attended the GIC there when they were 20 years old. They depicted through both “Building on Health Care” and “You Change” that CAMH had a psychiatric environment where being trans felt like a disease compared to the affirmative trans-led community care he now received.⁶³⁷

They also described undergoing multiple mental health assessments at the GIC, “When I went to the clinic, I met with two people that each did an evaluation with me. I think the first one was a psychiatrist and the second was a psychologist. I was nervous.” In their photo Pogi used

⁶³⁵ Day 1, *supra* note 14.

⁶³⁶ Ibid.

⁶³⁷ Pogi, *Building on Healthcare* (April 2017); *You Change* (April 2017).

the angle of the camera and the high contrast lettering of a blue and white sign to give a directional sense of industrial growth to an image. A person of colour in a dress wearing sunglasses to hide her identity, points with a single finger to the lettering on the sign. She seems marginalized because she is literally at the edge of the frame, yet she also seems deliberate and aware. Perhaps this editorial gaze is Pogi's recognition that while CAMH has a negative historical connotation for many trans people across Ontario, due to its practices, its low referral rates for surgery, and its waiting lists, there are some people who would say they benefitted from CAMH services.⁶³⁸

Both Pogi and Sakura River shared that they had been institutionalized as minors and as young adults. Both created photographs that evoke the unsettling control and invasion of surveillance and knowledge production.⁶³⁹ Pogi's photograph, "Building on Health Care", displayed their perception that CAMH prioritized institutional budgets and research goals over the needs of consumers. They called the structure the "medical industrial complex".⁶⁴⁰ Meanwhile, Sakura River gave two examples supporting Pogi's opinion. The message of their Bloody Glove series on neglect in health care was emphasized by their choice of alleyways in close proximity to CAMH as the location:

I've been to hospital so many times for either suicide watch or something, or panic attack, I was never given the health care that I needed at that time, because the hospitals either didn't believe me, or didn't care.⁶⁴¹

Unfortunately, when I had issues with my mental health I was in hospitals, they never seemed to understand me as a person of trans experience as I continually asked to be

⁶³⁸ Day 2, *supra* note 607.

⁶³⁹ Michel Foucault, *Discipline and punish: the birth of the prison*, 2nd Vintage books ed. ed (New York: Vintage Books, a division of Random House, 1995) at 25.

⁶⁴⁰ Day 2, *supra* note 607.

⁶⁴¹ Day 1, *supra* note 588.

called my preferred name and pronouns but was never shown the courtesy in situations with ER [emergency room] professionals. I always say quotations of professionals.⁶⁴²

Despair comes across as a resulting sub-theme in Sakura River's Bloody Gloves series where black-hooded figures loom in graffitied alleyways wearing bloody medical gloves. Sakura River depicts feeling neglected and disbelieved in part because of sounding articulate and assertive and in part because of experiencing health care as an impersonal bureaucracy.⁶⁴³ While other factors such as unsupportive family members and poverty were named as barriers by Sakura River, what two participants emphasize here as a partial reason for inadequate mental health care is the frightening impersonal institutional nature of mental health services in hospitals.

Interpersonal, Professional and Organizational Issues

This next thematic section digs deeper into the results, offering a meso-level analysis of their experiences with health care provider organizations, and the practices, behaviours and attitudes of health professionals. Sub-themes include inaccurate assumptions by doctors, racism, negative attitudes from a variety of health care providers, and lack of service provider accountability.

Doctors' Inaccurate Assumptions about Trans People

Two participants shared a common experience of being slotted into the white/Western medical model of linear transitioning discussed in Chapters 1 and 4. Participant #4 noted that the assumption held by doctors they encountered who had some familiarity with trans patients is that

⁶⁴² Sakura River, *Bloody Glove Series* (April 2017); Day 1, *supra* note 588.

⁶⁴³ This experience was documented since the 90s in the writings of Dallas Denny who describes how the stereotypes of gender clinicians about "real transsexuals" presented i.e. desperate, crazy and loud became selection criteria for everyone who came for services see Denny 1991, *supra* note 122.

everyone aspires to medical transition with hormones followed by surgeries. They also met doctors who work with trans people who immediately assumed medical transitioning was the point of the visit: “Sometimes a trans person may want to visit a service provider for needs not directly related to their transness, but service providers may want to focus on the transness anyways.”⁶⁴⁴ As Pogi said friends warned them about doctors’ binary beliefs about gender: “Like don’t talk about nonbinary or genderqueer identities. Don’t mention any sort of hesitation or confusion about identifying with the opposite gender you were assigned at birth.”⁶⁴⁵ Participant #4 recounted an experience at a clinic near Toronto’s gay village where, “in sort of my experience visiting this doctor I was like, ‘hey I don’t really know what’s up, I don’t wanna visit my regular family doctor, ‘cause like I can’t talk to her and blah blah blah’, so he was like ‘so you want to start T right?’ And I was like ‘Nooooo’, and he’s like yeah, ‘but T?’”⁶⁴⁶ Participant #4 was clear that they were not currently interested in medically modifying their body although their social and personal transness is very important to them.

Two participants also identified doctors’ assumption that all of a trans person’s medical needs are transition-related when in fact, as Pogi commented, “Trans people have a butt load of health needs that are no different from cis people’s, like skin and feet etc.”⁶⁴⁷ This assumption made it difficult for them to obtain referrals for other health issues such as dermatology and physiotherapy.

Furthermore, a common experience for participants was that straight and cis health care providers assumed that as trans people they were also gay based on their appearance or having a

⁶⁴⁴ Day 2, *supra* note 607.

⁶⁴⁵ Ibid.

⁶⁴⁶ Ibid.

⁶⁴⁷ Pogi, Pre-focus group survey, *supra* note 592.

“girlfriend”.⁶⁴⁸ As Participant #4 pointed out, transphobia and homophobia are codified at many levels, “It goes as deep as standardized checklists, that has [sic] the wrong questions, male, female, other, or like ‘who are you having sex with?’ that doesn’t even ask what kind of sex I’m having.”⁶⁴⁹ Assumptions made by doctors then limit the information and choices that are presented to LGBTQ youth eroding full expression of their own gendered and racialized selfhood. Participant #1 said: “I guess to them there are certain ways of being trans, like a lot of, I don’t know, if you can’t really be anywhere on the spectrum, like non-binary identities, and a lot of other identities, a lot of POC trans folks are just excluded from this.” Participant #4 described being offered limited information about reproductive health because the doctor assumed they would not want to become a parent.⁶⁵⁰ They said, “And that sort of gets into like family building stuff because I think there’s a particular perception about particular queer and trans communities that having kids isn’t a thing they’d be interested in.”⁶⁵¹

All participants expressed the overarching critique that doctors expected that medical needs should be visible and able to be communicated in language that a cis straight and often white doctor could understand. For example, Pogi explained the dissonance of using technical and emotional language to get their GD diagnosis, “I just felt like I had to use language I wouldn’t normally use? Like I had to figure out how to communicate all these things I had never properly articulated out loud to myself.” Participants were disappointed that doctors did not try different methods to elicit information from them after establishing a trusting clinical relationship. As

⁶⁴⁸ Day 1, *supra* note 588.

⁶⁴⁹ MC, *supra* note 603.

⁶⁵⁰ Day 1, *supra* note 588.

⁶⁵¹ Ibid.

Participant #1 put it, “doctors don’t start by building trust they just start by asking a bunch of hard questions.”⁶⁵² Similarly, Participant #4 commented:

And so like, there needs to be better ways for healthcare professionals to be like getting this information, and I feel like part of this is just like ‘Oh no, it’s taboo to talk about unconventional things’ and so doctors want to navigate it in a weird way, maybe don’t feel awkward about it but they feel like the patient might feel awkward about it and so they’re trying to like keep it on the down low or something...⁶⁵³

Inaccurate assumptions presented challenges to care, and as results suggest below, participants showed variety of responses.

Racism

Participants identified race/ethnicity as a determining factor in health care in several ways. Participants had all used queer and trans youth group programs at some point. They found that white youth dominated queer and trans spaces and group discussions at community centres and community health centres.⁶⁵⁴ Three of the participants pointed out that accessing programs, services and treatment appeared easier for white trans youth because of their greater numbers. Participant #1 described being lumped “together with white and binary youth”. The consequence of majority white spaces was as Sakura River observed “a lot of the spaces in which it’s for trans people and other people like that, it’s a lot of Caucasian or white people who speak over everyone else.” Regarding the whiteness of a queer drop-in space Participant #1 said:

Because you need someone who knows what it’s like to be racialized and have not have that passing privilege. And just the fact that they didn’t have that at all, or recognize that they needed like one counselor at least, just for those folks. It was very upsetting. And

⁶⁵² Day 1, *supra* note 588.

⁶⁵³ Ibid.

⁶⁵⁴ Ibid.

then the space quickly became much more like white, because it's just like, you don't seem to value the racialized communities coming here, so it's not safe.⁶⁵⁵

Despite the supportive presence of some BIPOC facilitators running groups like BQY (Black Queer Youth) and Transfusions Crew, the Sherbourne Health Centre's Supporting our Youth programming and EGALÉ's Youth Drop-In were mentioned as spaces where white dominance and racism were consistent.⁶⁵⁶ In terms of how race influenced the geographic placement of funded services for trans people, Participant #4 said, "I think specifically in the context of Mississauga, there's a lot of people like, "Of course there's no queer and trans services in Peel because there's so many racialized people."⁶⁵⁷

According to participants, therapists and counsellors they encountered rarely demonstrated anti-racist approaches to therapy and sometimes displayed culturally inappropriate behaviour. Participant #1 described their search for a trans positive therapist this way:

Like when I was like really new I was looking for counsellors, and I guess the first place seemed like a, like it seemed really good on the outside, then like my counsellor started like teaching me yoga, and all these appropriated methods to like be in the now and she started saying namaste a lot and it just got to this point where I was like, no. And I was here, looking all over town for like a counsellor who was POC who had immigrant experience, who was queer you know, and like it was really hard.⁶⁵⁸

Two participants agreed that trans and gender terminology are culturally defined by white people. Participant #4 commented on how the diagnostic standards reflect this whiteness stating:

I used to have this joke in the queer community where like 'what does a non-binary person look like' a skinny white person with like the side-cut and like they wear plaid button ups and ripped jeans and doc martens. This is what a queer looks like. Not just

⁶⁵⁵ Ibid.

⁶⁵⁶ Ibid.

⁶⁵⁷ Ibid.

⁶⁵⁸ Ibid.

what does it look like, but what does it mean to be this way. This is how we summarize what the experience is. They have just the right amount of dysphoria and this is how they do relationships and who they do relationships with. And this is not all people's experience, and this is erasing a lot of people's experiences.⁶⁵⁹

Results demonstrated that despite the struggle to find other trans racialized youth and anti-racist service providers, the participants at least had a desire to connect with BIPOCs instead of assimilating into whiteness.

Attitudes of Health Care Providers

From participants' experiences other health care providers like nurses, and emergency medical staff as well as technicians and receptionists appeared to be as racist and transphobic as doctors. Participant #1 described the attitudes of health care providers, "I feel like health care service providers get particular images in their learning, that's centred from media, because they're also immersed in popular culture too."⁶⁶⁰

One of the participants' worst experiences was the constant misgendering and outright refusal to use trans inclusive language in public hospitals and in the emergency room. Despite gender dysphoria being an official mental health diagnosis, two participants encountered mental health professionals who refused to respect that diagnosis by using correct names and pronouns.

Regarding the trans competency of technicians Participant #4 recounted this story:

I took an MRI once and the person, and I was like there in like...this was forever ago when I used to bind so, the person asked me if I was like wearing a bra or whatever and I was like 'Nope' and the person was gendering me using like he/him pronouns, and

⁶⁵⁹ Ibid.

⁶⁶⁰ Ibid.

then like I gave them my health card and they were like ‘OH! You’re a girl!’ and I was just like, fuck this. Good thing I don’t have to talk to you ever again.⁶⁶¹

This experience also shows the long-term impact on Participant #4 and their resulting sense of futility in addressing and educating the MRI technician who appeared to be cluelessly transphobic and urgently needed some trans inclusivity training.

Sakura River created their unsettling “Bloody Glove” photo series to depict how health care professionals destroyed their autonomy in health care decision making with their neglect, cruelty and shaming.⁶⁶² Their triptych was shot in a graffiti covered alley in close proximity to CAMH using their cousin and partner as actors. In the first picture, a black-clad figure faces the viewer and pulls off a bloody medical examination glove. In the second picture, the clad figure has their back to the camera, as they hold a glove in their blood-covered hands. More bloody handprints move diagonally across the bottom right of the frame towards the creepy figure ending in a second discarded bloody glove. In the third picture the black clad figure chases another person in the alley. The images intended to show the fear and pain Sakura River experienced in almost all their experiences in health care:

I wanted it to evoke strong emotions on people. It’s more so the neglect part, from the healthcare system. I just wanted to portray a very ominous mysterious, upsetting feeling. Uncomfortable feeling. When dealing with healthcare professional quote unquote. When dealing with them, they haven’t understood most of what’s going on with mental health issues or things related to my gender, and this represents the neglect that I felt with the healthcare system, see he’s turning away and just leaving a trail. Like, doctors have done this to me a lot.⁶⁶³

⁶⁶¹ Ibid.

⁶⁶² Sakura River, *Bloody Glove Series 1* (April 2017), *Bloody Glove Series 2* (April 2017), *Bloody Glove Series 3* (April 2017).

⁶⁶³ Day 2, *supra* note 607.

Two participants mentioned that non-medical staff in doctors' offices and hospital clinics also displayed transphobic, racist and ableist attitudes.⁶⁶⁴ Another example of corollary office staff displaying oppressive attitudes was shared by Sakura River who had been extremely "excited and terrified" on Day 1 about an upcoming appointment with "a trans mental health friendly doctor, that I'm going to and finally I can be like, heeeeeeeeey doctor that can help me!"⁶⁶⁵ However on Day 2 they reported back that because they were late for the appointment due to a panic attack they were told, by the receptionist they could not have another appointment.⁶⁶⁶ It appears that the receptionist for a mental health doctor would not accommodate patients who were tardy due to mental health issues. This incident suggests that the doctor's office did not adequately accommodate non-neurotypical trans racialized youth like Sakura River.

Health care providers that the youth encountered were not adequately trained about trans health care needs, which are not always different from cis people's health care needs. That said Participant #4 also said that service providers need to become more knowledgeable about trans people's experiences and their specific health needs.⁶⁶⁷ Participant #4 expressed the need for health care providers to see heterogeneity within social groups of people without simply relying on what they may have learned in a trans 101 training:

I used to people watch a lot. What kind of music does this person listen to? What does their bedroom look like? Who are they talking on the phone to? And how we never know and make all these judgements because we see people as background characters in our stories instead of their own people with huge microcosms of stuff going around them.⁶⁶⁸

⁶⁶⁴ See Participant #4's quote regarding the MRI technician above at 165.

⁶⁶⁵ Day 1, *supra* note 588.

⁶⁶⁶ Day 2, *supra* note 607.

⁶⁶⁷ MC, *supra* note 603.

⁶⁶⁸ Ibid.

Participants' discussions and their photographs reveal that their reactions to health care providers' attitudes and behaviours ranged from dissatisfaction to trauma. And yet it is to this group of people that participants had to turn to for primary and gender-affirming care. In the next section will look at how well management took responsibility for addressing these deficiencies of health program delivery.

Lack of Accountability from Service Providers

Participants expressed dissatisfaction that organizations they visited for health care were not responsible to them about the quality of services provided in several ways. For example, some organizations did not explain programming changes and staff turnover in a transparent manner. Participant #4 suggested that the level of neglect is even higher when dealing with racialized communities in East Mississauga.

Like the community health centre's mandate was that it was supposed to be like, prioritizing newcomers and like trans folks and racialized folks, but that's not actually what was going on... And then for an example they had a lot of people being accepted as new patients, most of them weren't newcomers or racialized folks, and they were doing that on purpose, and no one was willing to say anything about that.⁶⁶⁹

Participant #4 referred to the implosion of services for queer and trans BIPOCs at East Mississauga Community Health Centre in 2015 when management's transphobia and racism resulted in the firing of non-binary POC workers and the loss of doctors serving trans patients

⁶⁶⁹ The Black participant did not refer to themselves as Black, but rather as a person of colour and spoke of racism generally instead of anti-Black racism, so it is inconclusive how they felt about any distinction amongst racialized people.

but “they didn’t tell patients that he had left” and “they haven’t actually addressed the shitty stuff they’ve done...so it’s like how are you expecting folks to come back to your space when you’re not willing to adjust the shit that you did in the past.”⁶⁷⁰ Participants experienced staff turnover and programming changes intensely because of their great vulnerability when faced with unknown health care providers.⁶⁷¹ Similarly, Participant #1 spoke of feeling a loss when competent and racialized counsellors and workers of colour staffing the EGALE youth drop-in disappeared with no explanation when their services were deeply appreciated by trans racialized drop-in users.⁶⁷²

Participants wanted organizations to take responsibility for properly training their staff to be adequately informed and comfortable with BIPOC trans people.⁶⁷³ Furthermore, participants suggested that regular mandatory intersectional anti-oppression training needed to be provided for front desk staff and health technicians.⁶⁷⁴

Supporting our Youth (SOY) programming at the SHC was described as more responsive to trans racialized youth than other locations because they allowed for involvement of supportive family members through Gender Journeys program and the existence of two anti-racist trans facilitators. However, two participants mentioned the majority whiteness of the group’s participants as an alienating factor.⁶⁷⁵

CAMH was considered useful because for many of the years it was the only place operating subsidized services. However, only Pogi tried to use the CAMH GIC at age 20. Pogi said, “I was

⁶⁷⁰ Day 1, *supra* note 588.

⁶⁷¹ See additional supporting quote from Participant #4 below at 169.

⁶⁷² Ibid.

⁶⁷³ MC, *supra* note 603.

⁶⁷⁴ Ibid.

⁶⁷⁵ Day 1, *supra* note 588.

looking for other ways to start HRT”, and they simultaneously attempted Planned Parenthood, “it was confusing for me to navigate” and the Sherbourne Health Centre, “there was the factor of me not living close enough”.⁶⁷⁶ Ultimately it was Pieces to Pathways who facilitated their gender affirming care through effective referrals to doctors.

Impacts of Barriers on Participant Mental Health and Access to Care

All of the participants described experiencing some type of anxiety related to the structural vulnerability of being a trans racialized youth. Most significantly participants expressed anxiety about entering health spaces, for instance Participant #4 said:

I believe my mental health is linked with anxieties around being misgendered or not respected because of the ways I’m visibly racialized or that I’m fat. I have a lot of anxiety about entering new spaces and needing to start from scratch with people; doing all the explaining and going through the steps of physicians pathologizing my identities or straight up not believing me like they’ve done in the past.⁶⁷⁷

And Pogi said for example they consider “navigating potential services that won’t be trans friendly and being mindful of white dominated services” and spent energy “gauging how to present and if I can deal with the stress, impact, of uncomfortable conversations, confrontations.”

Sakura River identified another way they experienced anxiety:

So, the doctor decided to believe her [mother] over me when I was in the hospital one time, and I needed something to calm down my system because I was stuttering for six hours. But for the longest time the doctor was just like, ‘well you just need to eat better, you need to sleep better’ blah blah blah. ‘How’s your school life? How’s your family life?’ blah blah blah. And this continued on for every single doctor I’ve tried to have help with anything. They’re always like, ‘oh eat better.’⁶⁷⁸

⁶⁷⁶ MC, *supra* note 603.

⁶⁷⁷ Participant #4, Pre-focus group survey, April 22, 2017.

⁶⁷⁸ Day 1, *supra* note 588.

Participant 1 said: “Those things are also usually small moments in passing that like, it’s not that it doesn’t affect you, because sometimes it does it like hits and then it’s there for like days and weeks and months afterwards. But for that person it’s just a moment in time and like...”⁶⁷⁹ Finally, two participants made the choice to protect their mental health over addressing physical health. Pogi said: “I have been prioritizing mental health over physical, because navigating spaces semi-aware of my backgrounds is too much.”⁶⁸⁰ Sakura River said that their health concerns were “a lot of mental health things’ cause it controls my life”.⁶⁸¹ This shows their struggle for autonomy to recognize and seek help for all their health issues. They have had to make the choice against their interests to leave aside physical health concerns because they felt their mental health had a greater urgency. These thematic results suggest that structural, systemic, professional, organizational and interpersonal barriers had a lasting impact on participants whose anxiety often kept them from accessing care in a timely fashion or at all.

Protective Strategies

Participants described agentic decision-making practices in health care to mitigate harm in the face of barriers. This next section unpacks those results.

Performing Identities

⁶⁷⁹ Ibid.

⁶⁸⁰ Day 2, *supra* note 607.

⁶⁸¹ Ibid.

As discussed earlier in Chapters 1 and 4, a gender dysphoria diagnosis is technically required before clinicians approve a trans person for puberty blockers or hormone therapy. Participants shared how gender role performance was required to convince gatekeepers of one's gender dysphoria as Pogi explained:

I really wanted to get on Testosterone, and I had heard that when it comes to CAMH there's not a lot of room for exploring your gender if you want to get HRT or surgery anytime in the next three years. So, I had to develop and practice a narrative of gender dysphoria. I also was diagnosed with type one bipolar disorder, so there was some gatekeeping. I had to adhere to an image, and I still do, in order to get on T after three years and now to access medication. This is what the photograph Dick Pick is about.⁶⁸²

Pogi further described their gender performance in order to get cross sex hormones:

I just mean I had to do the typical FTM trans man, I've always known that I was this way, I'm a man trapped in this body so like I go in there and I'd never act feminine, my voice would be monotone. I had to play dude.⁶⁸³

This is a perfect example of the simulacrum – the fraudulent imitation that comes to represent authenticity.⁶⁸⁴ These passages show that emancipated youth regulated their behaviour especially when attempting to obtain gender-affirming or mental health services. They had to repress feelings of anxiety, fear, anger and frustration when in front of health care providers thus being read a certain way and not having their underlying stress seen/heard or believed.⁶⁸⁵

⁶⁸² Focus group participants, *supra* note 14.

⁶⁸³ Ibid.

⁶⁸⁴ Theorist Jean Baudrillard used the term simulacrum to mean false copies of a thing that come to precede the thing itself Jean Baudrillard, *Simulacra and simulation, The body, in theory* (Ann Arbor: University of Michigan Press, 1994); see also Thomas King who applies the simulacrum to the inaccurate stereotypes of Indigenous people that come to represent authenticity; Thomas King, *The Inconvenient Indian: a curious account of native people in North America* (Toronto: Anchor Canada, 2013) at 54.

⁶⁸⁵ See Pogi below for supporting quote at 173.

Besides gender performance, youth identified a second type of identity related performance. Participant #4 described carrying their cane at all times so people acknowledged their disability. They explained using performance to access accommodations through the photo “Grounded”.⁶⁸⁶

Sometimes like people’s inferences as to what that means um, like, makes different reactions. and yeah, like it’s a really really big thing about like talking about navigation and accessibility and like performance and stuff like that. Like this isn’t a thing that I literally need, all the time, every day, but I carry it with me, all the time, every single day, because one, you never know, and two, people get what this *Taps cane* means usually.⁶⁸⁷

Participant #4 also tried to convey the performance of marginalized identity through the photograph “Discarded, Forgotten Hidden and Sometimes Compartmentalized”.⁶⁸⁸ In both photographs the cane is disconnected from the person holding it and it is not positioned in a typically recognizable way. In “Discarded” the cane lies on the ground like garbage making the viewer wonder about how it got there. In the photograph “Grounded” the cane is more assertive as it points to the feet of the person holding the cane as though to ground them.⁶⁸⁹ In both photographs I interpret Participant #4 as trying to share different internal and external meanings of themselves as a physically disabled trans racialized youth using the cane in different scenarios to signify disabling physical and social structures.

Participant #4 also said they could still be disbelieved while using their cane. They recounted an experience of taking public transit with a group of BIPOCs who were all using mobility devices. Other transit users asked if their collective use of mobility devices was part of a trend.

⁶⁸⁶ *Grounded*, *supra* note 613.

⁶⁸⁷ *Day 2*, *supra* note 607.

⁶⁸⁸ *Discarded*, *supra* note 717.

⁶⁸⁹ For another supporting quote on disability performance see Participant #4 below at 175.

Participant #4 thought that being racialized also contributed to people invalidating their access needs.⁶⁹⁰

Three participants described how they were not believed and therefore not diagnosed by mental health service providers because they were not demonstrating recognizable indicators of “crazy”. For instance, Pogi recounted that:

A psychiatrist doesn't think I have bipolar. Because I haven't had a manic episode in like 3 years. Because I've been presenting very calm. I think it's the Asian in me that's like I have to put on my best face for this adult. Like “yes I'm stressed I do mindfulness yoga.”⁶⁹¹

They explained that as trans racialized youth they did not feel safe entering emergency rooms or clinics in states of obvious distress.⁶⁹² Generally the participants were adept at switching from one set of representations to the next in order to best succeed in obtaining what they needed. Yet, in the mental health context they did not reveal their distress, or perform crazy to get a diagnosis because they were afraid of the consequences such as being found incapable and being institutionalized.⁶⁹³ Performance so far has been explained as a way to obtain medical services and treatment; however it can also be a disidentification practice to resist the imposition of dominant categories, which I will turn to next.

Disidentifying with the Gender Binary

⁶⁹⁰ Day 2, *supra* note 607.

⁶⁹¹ Day 1, *supra* note 588.

⁶⁹² Ibid.

⁶⁹³ Ibid.

In their image creation process trans racialized youth infused their awareness of the influence of dominant social categories into their photographs. This act engaged what bell hooks calls the “visual politics of seeing” which goes beyond participants just packaging up good or bad images of themselves.⁶⁹⁴ Results showed different types of transphobic behaviour relating to experiencing gender dysphoria; here results reveal the impacts of overly rigid gender boundaries. Besides “trans” participants used terms like “gender non-conforming”, “non-binary” and “gender-weird” to describe themselves.⁶⁹⁵ Participants showed how they manipulated the gender binary imposed by law and medicine Pogi’s photograph “Dick Pick” depicts the act of resisting the gender binary while existing within the gender binary.⁶⁹⁶ At the centre of the photograph is a person’s hand holding their dick between their thighs. The viewer’s eye is drawn to the corridor formed by the person’s thighs leading to the row of clothes hanging across the back of the photograph. The row of clothes is divided into two sections. One section is masculine, and one section is feminine/gender neutral. The creation of this image is a disidentificatory act, because Pogi is aware of the falsity of the gender binary system and knows they must exist within it. Therefore, when in public they will choose their way of playing with this falsity. In addition to considerations in terms of finding the right biracial-shaded prosthesis, they are also choosing what type of clothes to wear from each side of the closet where their differently gendered clothes hang.⁶⁹⁷

There were many situations when participants had to decide how to navigate spaces where they are not out as trans and they may not fully pass to cisgender people as a recognizable

⁶⁹⁴ hooks, 1995 *supra* note 201 at xii, 2.

⁶⁹⁵ Focus Group participants, Pre-group survey *supra* 592, and Day 1, *supra* note 588.

⁶⁹⁶ Pogi, *Dick Pick* (April 2017) in it Pogi is humourously playing on the cis male practice of sending people photographs of their genitalia, known as “dick pics”.

⁶⁹⁷ See description of “Dick Pick” in section Performing the Simulacrum below.

gender. Pogi mentioned a time when at the dentist, they pretended to be sick to mask the way their voice changed once they started taking testosterone. As with other health service providers, they described gauging how binary female or male to look depending on how stressful being read as either gender identity would be for them in that space.⁶⁹⁸

Disidentification behaviour could also manifest as deliberately trying *not* to pass as a binary gender. Participant #4 illustrated their strategy of wearing wigs in photo “Who goes out? Who gets to be seen? Who am I to you?”⁶⁹⁹ The photograph shows an open closet door on which three long-haired glamorously styled pink, purple and copper coloured wigs hang. The bright wigs contrast with the white closet door and the blue walls of the room. The caption and the empty closet ask the viewer to consider how much their own perceptions and experiences determine how to read a person they might see, because as hooks wrote, the way we see is overdetermined by our location.⁷⁰⁰ Participant #4 emphasizes their bodily absence by placing wigs against an empty closet in a room they said they barely use.⁷⁰¹ They disliked their current hairstyle, and used hats and wigs. They also said they do not leave the house that much, and when they do, they wear sweatpants and clothes that conceal their body and gender.⁷⁰² In this way, “Who goes out?” questions the viewer’s way of seeing the subject without the subject present. In fact, it functions as Participant #4’s distanced self-reflection.⁷⁰³ The photograph could also be read as way of showing the artifice of gender through the long-haired brightly coloured wigs and the limitations

⁶⁹⁸ Day 1, *supra* note 588.

⁶⁹⁹ Participant #4, Who goes out? Who gets to be seen? Who am I to you? (April 2017).

⁷⁰⁰ hooks 1995 *supra* note 201 at 2.

⁷⁰¹ Day 2, *supra* note 607.

⁷⁰² Ibid.

⁷⁰³ Lutz & Collins, *supra* note 327 at 207.

of trans bodies to push the boundaries of gender. Participant #4 describes the use of tactical misrecognition:

There's a YouTuber I really like who did a video talking about finding your new normal, and she's disabled but she looks able bodied, and in her videos, you see her like dancing around but that's not how she looks all the time. People don't like talking about performance in this way. Like today I decided to wear knee braces even though they're ugly and obtrusive, and how that changes how movement is physically and socially.⁷⁰⁴

In “Reading Between the Signs”, Pogi disidentified with the cis medical gaze by demanding that the viewer identify with an unfamiliar aesthetic.⁷⁰⁵ Pogi took a full-colour picture from across the street facing a small park near the CAMH facilities on Queen Street which they noted was spruced up in the last few years as part of a neighbourhood gentrification project.⁷⁰⁶ The viewer’s gaze is directed to a brick wall at the back of the photograph painted with the large white block letters “YOU CHANGE”. The rest of the photo shows the empty park with a recycling receptacle in the foreground. Pogi talked about how the park featured benches that had been designed to prevent people from sleeping on them. Pogi deliberately created the directive phrase “YOU CHANGE” by positioning of the camera in such a way as to block the last (and missing from the photo) letter “D” with a street sign. Pogi said that one meaning in this image is that the cisgender doctor requires the trans person to change in a familiar and recognizable way so that the cisgender doctor can approve of the trans person’s identity.

Both Participant #4 and Pogi used photography not just to depict their own reality for the viewer’s consumption, but editorially to make the viewer think about how they see other people based on pre-existing categories and familiar narratives. In Pogi’s “Reading between the Signs”,

⁷⁰⁴ Muñoz, *supra* note 134; Day 2, *supra* note 607.

⁷⁰⁵ hooks noted this same technique in hooks, 1995 *supra* note 201 at 4; *Reading between the Signs*, *supra* note 636.

⁷⁰⁶ Day 2, *supra* note 607.

I saw Pogi using gentrification as a metaphor for the cisgender expectation of transnormativity in health care settings. By changing the mural for this photograph, Pogi defamiliarizes the cis gaze and thus forces the viewer to see the park, the trans person and themselves in a new way. I liken this editorial gaze to a disidentification with the cisgender viewer's gaze.

Avoidance of Medical Care

None of the participants was accessing all of the health care services they needed and wanted however they described different degrees of access and for varying reasons. Of the four youth participants, two of them avoided medical appointments with doctors, nurses and health technicians because of prior experiences of transphobia and racism. The other two were dealing primarily with mental health issues that were not, in their opinion, solely trans related. Of the latter two participants, one had already secured their cross-sex hormone replacement therapy and wanted to be approved for top surgery once they had been on testosterone for the required length of time. The other participant was trying to socially transition before trying to access cross sex hormones which they had been refused more than once.

Participant #4 was one of those who experienced multiple layers of oppression in health care settings and exercised their agency to avoid health care altogether. Their photo “We Spend Some Time Together and Avoid the Medical Gaze” shows a person from the neck down facing the viewer, wearing fitted brightly coloured clothes.⁷⁰⁷ The person is holding leash attached to a small dog that is standing on a low small wall as if around a pond. The lighting comes from natural sunlight. This picture showed a protective response to the total stress and exhaustion of

⁷⁰⁷ Participant #4, We Spend Some Time Together and Avoid the Medical Gaze (April 2017).

going to their family doctor for tests, a doctor who misgendered them and told them to lose weight. Rather than start looking for a new doctor, they went for a walk with a friend and their dog. Participant #4 is not even in the picture, implying their own desire to disappear in the face of the doctor-induced stress. They remarked:

The theme for these pictures is 'Me Avoiding Going to the Doctors.' because, it's [laughter] a real thing that's happening right now, where I went to the doctor recently and the doctor was like 'Okay we have to take a bunch of tests'...and then I was trying to get the doctor to like write a referral to me to get an assessment for a thing and she's like, 'I can't write an assessment because we need to do these tests first, and also I lost some of your information because you haven't been here in however many years', and so, I was just like 'This is me not going to the doctor' because I don't wanna do the hassle.⁷⁰⁸

Participant #4 stated that their health care priority was: "Feeling safe in accessing spaces regardless of how much they're needed is extremely important to me and I cannot enter into a space without that understanding of safety from service providers."⁷⁰⁹

Sakura River also described attempting to avoid emergency medical care for financial reasons. They tried not to go to the emergency room after a fall at work: "And my brain immediately went to my finances, what if I have a concussion? What if I have to go to the hospital? WHAT IF I HAVE TO GO TO THE HOSPITAL?"⁷¹⁰ Their boss insisted they get checked out and subsequently, their experience at the emergency room could be characterized as several hours of being continuously misgendered by each staff person they encountered even with their partner there to advocate for them.

⁷⁰⁸ Day 2, *supra* note 607.

⁷⁰⁹ MC, *supra* note 603.

⁷¹⁰ Day 2, *supra* note 607.

In this thematic area, trans racialized youth participants described making agentic choices to protect themselves from further negative experiences with health care providers despite wanting medical attention for a number of health care issues. The way that Pogi described their mental health strategy was either to put off formally dealing with concerns until they had passed the thresholds for obtaining desired gender affirming treatments or to delay their medical transition until they felt their mental health issues were less of a priority. This is a very difficult decision for youth since gender dysphoria causes significant psychological distress.

Hiding

Participants used hiding as another agentic protective response to feeling a lack of autonomy in relationships and in relation to their own health and well-being. Participants hid in different ways and to different degrees. Whether they hid at home, from society, the medical world or their family of origin. This was due to the need to psychologically recharge from the multiple layers of oppression they experience daily. Hiding from doctors was best expressed above by Participant #4 in the photograph “We Spend Some Time Together and Avoid the Medical Gaze”.⁷¹¹

Sometimes participants used baggy clothes to hide birth-assigned gender or as a response to fat phobia. While fashion was an extremely important interest of three of the participants, two of those who loved fashion often did not want to wear body conscious clothes that garnered attention when going to the doctor, for example. As Participant #4 described in an earlier quote how tight clothing exacerbated gender misrecognition problems at the doctor’s office. Sakura

⁷¹¹ Participant #4, We Spend Some Time Together and Avoid the Medical Gaze (April 2017) [Medical Gaze].

River also said they wanted people to know they were gender fluid however in many situations they said they hid their gender identity like a “trans ninja” for their own safety.⁷¹²

For Participant #1, discomfort with public attention caused to them not to take pictures outside in a crowded street during the Day1 training shoot. They said that because they were already subjected to a lot of public scrutiny they did not want to take pictures in public.⁷¹³

Resilience Strategies and Autonomy Practices

Through focus group discussions and photo analysis the following practices emerged: integration of self, self-advocacy, intentional social networks.

Integration of Identities into Selfhood

All of the participants referred to themselves intersectionally and strongly resisted being compartmentalized by single issue or identity. Participant #4 was adamant that the sum of their vulnerabilities made their experience of health care uniquely alienating: “being plus-sized person being BIPOC and cripp and trans and all these things influences ...experiences that happen and what I get in health care spaces because of a lot of fat phobia and racism.”⁷¹⁴ In a similar vein, Participant #1 said: “...it’s not like cis people just see me as a Paki, or just as a feminine person, or non-binary. They [doctors] see me all at once; I mean they don’t ‘see’ me they ‘read’ me

⁷¹² Day 2, *supra* note 607.

⁷¹³ Day 1 Notes, *supra* note 593.

⁷¹⁴ Focus group participants, *supra* note 14.

through my clothes, my accent, my makeup.”⁷¹⁵ Their desire to integrate their identities into their unique selfhoods is beautifully captured in Participant #4’s photograph “Discarded, Forgotten and Hidden. Sometimes Compartmentalized”.⁷¹⁶ In this photograph, a cane lies askew in a parking lot near garbage and recycling bins. The cane symbolizes their experience of being disabled and of being read by others as disabled.⁷¹⁷

At first Sakura Rivers expresses the difficulty of their interlocking identities: “It is difficult to represent myself as a trans BIPOC person as well due to my having mental health issues, many don’t seem to want to believe that I do, most likely due to my being gender fluid as well as Hispanic.”⁷¹⁸ Still, two of their photographs show their integration of identities as resistance: “Flags” and “Light after Dark”.⁷¹⁹ In “Flags” Sakura River stands in full colour in centre frame addressing the viewer with their confident gaze. They might be riffing on the practice of flagging mentioned in Chapter 2 where a queer person reveals their queer identity using signals that only other queer people will notice. They signal their various identities and group memberships using referents such as the Pride flag, the Transgender Pride flag, and the Pikachu hat. In “Light” they captured a rainbow in a pink streaked sky from an apartment balcony. The rainbow arcing through the middle of the frame could represent Sakura River who incorporates several different elements in one charismatic personality. Sakura River seems to recognize that their interlocking identities and oppressions are key to their survival. Through these photographs and interviews participants express experiencing forms of violence in health-related contexts that cannot be reduced to silos of transphobia, ageism, racism, fat phobia or classism. Results show that the

⁷¹⁵ Focus group participants, *supra* note 7.

⁷¹⁶ Participant #4, Discarded, Forgotten and Hidden. Sometimes Compartmentalized (April 2017) [Discarded].

⁷¹⁷ Day 2, *supra* note 607.

⁷¹⁸ Focus group participants, *supra* note 7.

⁷¹⁹ Sakura River, *Flags* (April 2017), and *Light After Dark* (April 2017).

phenomenology of selfhood in health care is fundamentally intersectional for trans racialized youth.

Selfhood and Representation of Self

Self-image can be described as the way a person perceives themselves including their abilities, their physical presentation, and their mannerisms. It is the visual aspect of selfhood. Self-image can be especially revealing through photographs. Participants were not asked to take pictures of themselves but asked about how they tell their stories and their identities in health care contexts. As explained in these results, participants conveyed their self-image through images, symbols and omissions of themselves.

Being photographed and even taking photographs was not a simple activity for focus group participants. For example, Participant #4 refused to take pictures of their face: “I like actually didn’t want to take any pictures of myself, I think I took one picture of my face and I was like, fuck that because I don’t like looking at pictures of myself”.⁷²⁰ At first, I perceived they had a negative self-image from internalized negative messaging. In reflection, I considered hooks’ essay on Black relationships to image production and aesthetics. hooks theorizes:

Reflecting on the way black folks looked at themselves in those private spaces, where those ways of looking were not being overseen by a white colonizing eye, a white supremacist gaze, those images created ruptures in our experiences of the visual. They challenged both white perceptions of blackness and that realm of black-produced image making that reflected internalized racism.⁷²¹

⁷²⁰ Day 2, *supra* note 607.

⁷²¹ hooks, 1995 *supra* note 201 at 61.

In addition, I considered Prosser's statement that for trans people looking at their images could be both grounding and alienating depending on many different factors.⁷²² The absence of their face in photographs seemed to say, "I don't want to know how others see me."⁷²³ Participant #4 said: "And it's just like, I don't wear wigs most of the time, but I also don't leave the house most of the time. So..."⁷²⁴ With these three observations in mind then, I saw that for this participant, who struggled with internalized racism, fatphobia and transphobia, creating and viewing self-portraits had the potential for painful self-criticism. And yet while their pictures contain no headshots they do feature legs, feet and belly shots because they felt their "tummy is important" and "powerful".⁷²⁵ Through the "private space" of the focus group, they exhibited simultaneous negative self-image and resistance to it based on their understanding of internalized oppression.

We see Participant #4 stake their claim to beauty and self-love through the photo titled "I never said I was ugly. It doesn't make me sick".⁷²⁶ In the photo their naked belly dominates the frame, within its own dark-skinned subjectivity. Their belly addresses the viewer directly as though it has its own gaze. "I was specifically talking about how people are like 'oh, I'm so fat' or 'Oh you're so pretty!' like those are totally different things. No, I can be both fat and pretty."⁷²⁷ This is an act of tactical misrecognition. Participant #4 is fat Black trans and disabled. They know that society tells them they cannot be pretty and yet they use the word "Ugly" to

⁷²² Prosser, *supra* note 132 at 132 mentions factors such as whether the photographs depict pre or post transition and whether the trans person authored or commissioned the photographs. Prosser is notably silent on issues of race and ability.

⁷²³ *Ibid* at 213-15.

⁷²⁴ Day 2, *supra* note 607.

⁷²⁵ *Ibid*.

⁷²⁶ Participant #4, I never Said I was Ugly, It doesn't make me Sick (April, 2017) [Ugly].

⁷²⁷ Day 2, *supra* note 607.

show the viewer they reject that label. That same participant shared their hope and self-love in captions for other photographs. They captioned their cane, legs and feet shot “It’s a long way down, but there is more than one way to be grounded”. I take this as a description of a resilience strategy, where what could be disabling becomes affirming. Thus, the act of taking and curating images allowed Participant #4 to disidentify with mainstream beauty norms and to see beauty in their self-image despite always having to buffer society’s negative framing of their identities and their bodies.

Several of the youth’s resilience strategies were related to physical appearance. Participant #1 said: “the way we present ourselves can be a form of protection. Like, I wear a lot of makeup when I’m really anxious, and you wouldn’t think that, but I find the process very calming. It’s a buffer, femme armour.”⁷²⁸ Sakura River, Participant #4 and Participant #1 placed a great deal of attention on what they and others wear, even when they are purposefully hiding. Sakura River is part of a specific femme fashion community in Toronto. Clothing was also important to Pogi in the way that clothing is mined for gender clues by other people. In their photo “Dick Pick” Pogi is playfully deciding who to be, and how to look based on the feminine and masculine clothing on either side of their “dick” which acted as the barometer for the way their gender needed to switch. Participant #4 is an accomplished seamstress who makes and sells cosplay costumes for large and trans bodies and yet Participant #4 said they normally wore shapeless sweatpants to hide their body when they left the house.⁷²⁹ They may have been hiding themselves, but they balanced their love of theatrical fashion by making costumes for other people.

⁷²⁸ Day 1, *supra* note 588.

⁷²⁹ Day 2, *supra* note 607.

In order to represent themselves as a trans BIPOC person, Sakura River created the photograph entitled “Light After Dark”⁷³⁰ to depict how they move through the world as gender fluid and how they try to “make light of dark situations”. Sakura River took the photograph from an apartment balcony overlooking a grey urban landscape juxtaposed against a rainbow-hued sky after a storm. They described themselves as a “special snowflake” and explained that it is very challenging to remain positive in a world that did not like them due to being Hispanic, trans, poor, having mental health illness and being a youth.⁷³¹ Their self-conception involved beauty, positivity and playfulness. Despite daily attacks on their autonomy from structural inequity and their family of origin and they constructed their self-image by using contrasting colours, evocative lighting, multi-dimensional location and an optimistic caption.

Sometimes participants chose to show their self-image by using a self-referencing object instead of placing themselves in the photograph. Participants used props such as canes, wigs, prosthetics, knee braces hats, megaphones, rainbows and birds. Pikachu shaped cosplay hats appealed to Sakura River because Pikachu is a cheerful creature due to its yellow colour and smile. Thus, it was an appropriate self-reference to them as a small but powerful being. Pogi on the other hand, liked Pikachu because it is the genderless mascot for Pokémon and its image is energetic (it can shoot electric sparks) but not intimidating. The use of Pikachu is also a self-reference in “Alone Together” because Pogi is masculine but rejects stereotypically masculine aggression.⁷³²

⁷³⁰ Light after Dark, *supra* note 720.

⁷³¹ Day 2, *supra* note 607.

⁷³² Pogi, *Alone Together* (April 2017).

Other people appear in participants' photographs such as the person in Pogi's "Building on Health Care" and the person in Participant #4's "Medical Gaze". In both of those photographs the subject's face is hidden. In "Building on Health Care" the subject is a feminine presenting woman of colour wearing sunglasses.⁷³³ There is toughness about her signified by her non-smiling expression and her leather motorcycle jacket. She could be a version of Pogi's feminine side that is openly challenging the medical industrial complex in a way that Pogi would not do as them self. Then there is the person photographed with a dog on a leash by Participant #4 in "Medical Gaze". That person is the opposite of how Participant # 4 describes themselves and wears body conscious bright coloured clothing. The person is also Black and full-figured and is not hiding from the world. What participants choose about other people could also reflect what they like or do not like about themselves, and what they feel internally but do feel like they can externally embody in a photograph or in their daily lives. Photography then, has the potential to be a world-making act where hidden or aspirational elements of selfhood can be shown and therefore actualized.

Self-Advocacy

Youth outside parental control exhibited higher levels of self-advocacy and self-regulation in order to be seen as capable with respect to health-related decision-making activities, however all of the youth sought out health information and advocated for themselves which they found tiring. Participant #1 and Sakura River experienced the least family support. Participant #1 said:

⁷³³ Building on Health Care, supra note 639.

It just feels like there's so much more self-initiative that you need, when you don't necessarily have support. So it's kind of counter intuitive, like okay, I need people to support me because I can't support myself, like I don't have these people and the only way I can get to spaces that can support me, I need to be able to like, have enough self-care to do it.⁷³⁴

Pogi and Sakura River and carried out the most self-advocacy, and also were accessing more health care than Participants #1 and #4. Participant #1 remembered being discounted this way:

This happened when I had to get a reassessment for ADHD for school, and I was stressed so dressed really fancy that day. I wore like a weird outfit. So, I was talking about how I'm shy and socially awkward. And she was like, you don't seem like you are and it's like what the fuck, I'm telling you and you don't believe me.⁷³⁵

Sakura River related this experience:

So as soon as like I started showing mental health issues, my mom she gas lighted me the entire time, no you don't have these issues, blah blah blah, and when I went to the doctors for them, I tried my best to communicate what was going on.⁷³⁶

Assertiveness and informed self-advocacy seemed to confuse health care providers who had specific expectations of trans or neurodiverse youth. To put it in Pogi's words: "they [health care providers] don't seem to have an awareness that people will present differently in different situations."⁷³⁷

And finally, Participant #4 said regarding health care offices:

But you can't really go into that space without being informed. Because often they don't know anything, so you have to come in and like bring a stack of paperwork. But if you come with a stack of paper work they are suspicious because you know too much.⁷³⁸

Intentional Social Networks

⁷³⁴ Day 1, *supra* note 588.

⁷³⁵ Day 1, *supra* note 588.

⁷³⁶ Day 2, *supra* note 607.

⁷³⁷ MC, *supra* note 603.

⁷³⁸ Day 1, *supra* note 588.

Family of Origin

In the literature, family or adult support is established as a protective factor for trans youth. In this sample, participants did not mention family members as a source of support. Sakura River was the exception. Despite being estranged from their nuclear family, they were very close to their cousin who picked them up from the hospital, supported them and took part in the Photovoice project.⁷³⁹ Family relationships were not conducive to autonomous decision making, which would have required: respect for boundaries, demonstrating self-awareness, sharing information, and practicing decision-making skills.⁷⁴⁰

We know from the recent research reviewed in Chapter 1, and from anecdotal evidence from Drs. Bonifacio, Kaufman and Marasella that white trans youth and their families enjoy clinical and social service supports that BIPOC trans youth and their families do not.⁷⁴¹ Two participants described their families as transphobic; still, participants were not aware of any resources for families of trans racialized youth. Participant #4, a Black trans youth observed, “I think there’s also an assumption from outside of BIPOC that because x person is from whatever racialized group, of course their family is going to be more queer or transphobic.”⁷⁴² Participants also identified the same barriers noted in Chapter 1 by Dadui and Pyne that prevented BIPOC parents from supporting them as trans youth.⁷⁴³ The barriers for racialized families were English-only, culturally white uninsured services, with job precarity making it near impossible to take time from work to support children and youth with extra health needs.

⁷³⁹ Day 2, *supra* note 607.

⁷⁴⁰ Ibid.

⁷⁴¹ Dadui, *supra* note 124; Lee, *supra* note 53, at 87; Pyne 2018, *supra* note 35.

⁷⁴² Day 1, *supra* note 588.

⁷⁴³ MC Notes, *supra* note 621.

Community

On the other hand, all participants expressed the rewards of belonging or participating in community made up of friends, lovers, partners and acquaintances. Reliance on community is depicted in the photographs “Medical Gaze” (Participant #4), “Community Family Chosen or Otherwise Taking On The World Together”⁷⁴⁴ (Participant #4), “Flags” Sakura River and “Alone Together” Pogi. The photograph “Community” shows a group of ducks in a river under some hanging trees. Participant #4 compared the grouping of the ducks to members of their community where not everyone likes one another but people still try to help and support each other. Above the ducks, in the trees overhead, there is a large falcon that Participant #4 described as the common enemy. Eventually the ducks all made a big noise and stayed together and scared the falcon away. With this photograph they wanted to capture the dynamics of navigating difference and conflict within family and community groups and also collectively facing the common enemy who views all the ducks as the same.⁷⁴⁵

In “Flags” Sakura River is centred in the frame. Their body takes up the height of the frame. They are outdoors in a public field. They refer to several strands of their identity by using flags and a hat. They wear their Pikachu rave hat, the rainbow pride flag and the blue and white genderqueer flag. They proudly show their membership in three communities as part of their sense of self and the act of belonging appears to be validating and dynamic because of the movement of the flags in the wind.

Three of the participants were deeply engaged in cosplay communities. Sakura River and Pogi describe cosplay as an activity where they dress up in Japanese manga and anime costumes

⁷⁴⁴ Participant #4, Community, family, chosen or otherwise taking on the world together (April 2017) [Community].

⁷⁴⁵ Day 2, *supra* note 607.

with other similarly dressed players. Both use Pikachu hats in their photographs “Flags” and “Alone Together”. Sakura River describes their cosplay community as “caring, kind and fun-loving people” and says: “They respect me no matter what gender I present as or feel. They use all the correct pronouns, plus my preferred name...”⁷⁴⁶ Finally in “Alone Together”, Pogi shows themselves and a friend sitting on a log in the woods with their backs to the viewer, both wearing Pikachu hats.⁷⁴⁷ Friendship is depicted as a place of solace.

Peer Support Work

Peer support is a relational practice that involves people with a shared experience supporting each other through life challenges, validating each other’s feelings, sharing information, and building community. Two participants found being members of peer support communities to be fulfilling. Pogi worked at a youth mental health services organization. Sakura River was a peer support volunteer at an organization run by LGBTQ+ youth. They said, “There are other people who are POC like me who I’ve found, like me...but I don’t have that group of people to be all like, ‘You’re doing it! You’ve got this!’ except with [name of peer support group]. That’s the only people who like, understand the stuff I’m going through mostly.”⁷⁴⁸ Participant #4 repeatedly mentioned that they coordinated a monthly QTBIPOC youth meet up in a community-based health organization outside Toronto. In those youth spaces there was mutual information and skill-sharing, community-building and reciprocal peer support.

Finally, two participants made the choice to prioritize mental health over physical health. Pogi said, “I have been prioritizing mental health over physical, because navigating spaces semi-

⁷⁴⁶ Ibid.

⁷⁴⁷ Alone Together, supra note 733.

⁷⁴⁸ Day 2.

aware of my backgrounds is too much.”⁷⁴⁹ Sakura River said that their health concerns were “a lot of mental health things cause it controls my life”.⁷⁵⁰ This shows their struggle for autonomy to recognize and seek help for all their health issues. They have had to make the choice against their interests to leave aside physical health concerns because they felt their mental health had a greater urgency.

Discussion

Participant’s interviews and photographs resonated with the challenges of existence within an impersonal capitalist society characterized by systemic hetero/cisnormativity and precarity of life outcomes. They felt that health care provision and discourses limited the full expression of their identities.⁷⁵¹ This was in part as a result of the widespread use of versions of the acronym “LGBTQ” in health and social service fields lumps several sexual orientations and gender identities together for ease of service provision. As Han pointed out the resulting social grouping however ignores non-binary people, and Two Spirit people and forces straight identified trans people to obtain services in queer spaces. In addition to racism and transphobia, participants experienced differential access to care based on social determinants of health such as age, ability, body size, where they lived, citizenship status, class, income, and family support which supports Lee’s recent work on trans racialized youth.

Their desire for gender autonomy and integration of their identity categories deeply affected their mental and physical health. They described a range of health care related activities beyond giving informed consent that constituted the exercise of decision making. Participants spent time

⁷⁴⁹ MC, *supra* note 603.

⁷⁵⁰ Ibid.

⁷⁵¹ Sarkisova, *supra* note 329; Chang, *supra* note 120.

and care considering their gender identity related options and making decisions to minimize harm. They assessed providers, programs and physical spaces for safety and levels of racism, ageism and transphobia. Participants' responses to the barriers fall into categories of short-term protective/agentive or longer-term autonomy-enhancing.⁷⁵² Their agentive strategies were performance, disidentification, avoiding medical care, and hiding. Individual and collective autonomy-enhancing activities included integration of their identities, controlling their own self-representation, self-advocacy, participating in community and sharing information amongst peers.⁷⁵³

Participants preferred to make decisions with assistance from supportive and informed trusted people.⁷⁵⁴ They were afraid that doctors would allow unsupportive relatives to make health care decisions for them. When there were no trusted informed supportive adults to assist in decision making trans racialized youth relied on peers and community workers. They benefited greatly from safer, confidential and barrier –free health care services where they saw themselves represented.

According to participants, health care providers routinely failed to abide by informed consent rules when dealing with patients of all ages. This concern relates partly to the lack of access to rights-based legal information about the *HCCA* raised by Justice for Children and Youth in the previous chapter, and also to health care providers' insensitivity to issues specific to the autonomy of trans youth in decision-making such as hiding one's gender identity from family or being estranged from family.

⁷⁵² Sherwin 1998 *supra* note 157; Nedelsky 1989, *supra* note 157.

⁷⁵³ Hammond, *supra* note 78.

⁷⁵⁴ Paré, *supra* note 107; VanPragh, *supra* note 200; Geist, *supra* note 277.

Health care providers frequently breached confidentiality by seeking parental consent without a finding of incapacity and the resulting required notification process. Health care professionals held a number of pathologizing clinical stereotypes with respect to trans youth which worked against racialized and non-binary youth. Furthermore, participants knew that sometimes people do not want a physical change or that they cannot medically transition for physical and mental health reasons.⁷⁵⁵ Still others cannot medically transition for religious reasons.⁷⁵⁶ Participants were aware that medical transition was not approved for homeless or under housed youth, or those without the money for doctors' letters, unsubsidized travel out of province or who lack support for pre-and post-surgical care.⁷⁵⁷ These results support the proposition that eligibility criteria deselect for structurally vulnerable trans racialized youth.

Therefore, participants regarded doctors less as sources of support and information and more as gatekeepers. Clinical stereotypes and eligibility criteria coerced participants to implement agentic tactics. They described themselves to health care gatekeepers in terms matching the trans simulacrum in order to obtain diagnoses, hormone prescriptions and approvals for treatments. Doctors did not know how to broach topics of sexuality and gender e.g. safer sex practices with them. Participants also indicated that better listening skills and a patient-centred approach were needed to foster great autonomy in their decision-making. Their experiences suggest that the doctor's gatekeeping role undermined true practice of autonomy and the related activity of informed consent.⁷⁵⁸

⁷⁵⁵ MC, *supra* note 603.

⁷⁵⁶ Participant #1, Pre-focus group survey, *supra* note 592.

⁷⁵⁷ Day 1 Notes, *supra* note 593.

⁷⁵⁸ This confirms a finding about trans youth forming health information exchange networks in Hammond *supra* note 78 at 70 and 76.

While the participants had differing levels of insight about their own physical and mental conditions and the types of gender affirming treatments and services that exist in Toronto, they lacked important rights-based information about how to carry out the range of activities required for autonomous practice. Yet, in contrast to their lack of legal knowledge about health care consent and capacity, participants were well informed through peer community knowledge transfer about gender-affirming treatments, had adequate knowledge of services and had developed some strategies to address systemic barriers. Community knowledge transfer came through working and volunteering in peer support groups as well as participating in social communities that came together for art and performance. Others were compelled to self-advocate from a young age due to family conflict.⁷⁵⁹ Self-advocacy often was held against them, as it was not congruent with diagnostic criteria and paternalistic stereotypes that did not recognize the survival strategies of trans racialized youth and their families.

All participants used photography as a method of world making and self-validation. Art allowed them to employ the concept of disidentification by taking mainstream concepts, images and messages and reinterpreting them to be able to reflect themselves and critique those cultural products by making new ones. Sometimes not appearing in photos stemmed from participants discomfort with seeing themselves visually represented. In this Photovoice study the participants had complete control over what to show, what to share and what to release to me to use. So, while participants used hiding as an agentic strategy in Photovoice, in daily life that did not mean they wished to remain hidden. Hiding was a survival strategy that thwarted their autonomy.⁷⁶⁰

⁷⁵⁹ This supports Singh's finding about trans racialized youth's self-advocacy in the education system in Singh 2013a, *supra* note 50 at 696.

⁷⁶⁰ Judith Butler, *Excitable speech: a politics of the performative* (New York, NY: Routledge, 1997) at 136-39; Sherwin and McLeod 2000, *supra* note 181.

Health care providers and their organizations could have instead helped foster a sense of safety and appreciation for youths' integrated selfhoods.

The ability to perform a clinically recognizable gender identity to gatekeeping professionals was an essential skill for youth who need subsidized gender-related health services.⁷⁶¹ Put another way, the participants all donned the simulacrum of medically approved trans markers to access care. All the participants reported constantly feeling disbelieved by health care providers, which they attributed to a number of factors: the pathological combination of being trans racialized youth and in one case fat and with a physical disability and, in two cases due to mental illness. Furthermore, one participant said they deployed a stereotypical disability performance during interactions with most health care providers to counteract being disbelieved. Yet, while they perform, they do not necessarily conform. Their photographs show their critique through the disidentification process.

Self-acceptance was a conscious goal and a practice for all participants. This came across in many of their pictures. Pogi's "Reading between the Signs" and "Dick Pick" both reflect back agency and autonomy for what Pogi wants by questioning the normalcy of cisgenderness and declaring that gender is both relational and essential.⁷⁶² Sakura River's "Flags" exudes pride and unapologetic self-love in their engaged facial expression, direct gaze and confident posture.⁷⁶³ Flags is a clear message of adaptability and optimism in the face of struggle.⁷⁶⁴ Participant #4 resists internalizing racist, fat phobic and transphobic messages in "Ugly" and "Grounded". As the photographer, they reframe images of their fat, Black, disabled trans body showing the

⁷⁶¹ Denny, *supra* note 122, Namaste, 2000 *supra* note 75; Sarkisova, *supra* note 329, Chang, *supra* note 120, Thom *supra* note 132.

⁷⁶² Nagoshi and Brzuzy, *supra* note 135; *Dick Pick* *supra* note 697; *Reading Between the Signs*, *supra* note 636.

⁷⁶³ *Flags*, *supra* note 720.

⁷⁶⁴ Singh 2013a, *supra* note 50.

viewer constructions we may never have seen before but also forcing us to question our own application of mainstream beauty and ability standards.

As this phenomenology chapter attests, the participants were less concerned with producing positive visual representations and instead demonstrated a sophisticated cultural understanding of the politics of representation that challenged me as the researcher/viewer.⁷⁶⁵ The participants' marginalized positionality and their awareness of their own structural vulnerability compelled them to disidentify with dominant legal and medical narratives and mainstream aesthetic representations of them as trans racialized youth. They avoided reproducing stereotypes of authenticity that legal and medical constructions of autonomy would have ultimately painted them with.

In addition to self-advocacy and self-representation, participants used several collective strategies to increase their sense of calmness, relieve stress, alleviate depression and reduce isolation resulting from their intersectional and structurally vulnerable daily lives. These strategies allowed participants to bounce back from their experiences with health care providers and health systems.⁷⁶⁶ These strategies were also local autonomy practices because through them they shared knowledge, increased their sense of security, validated participants' selfhood and nourished their supportive relationships fostering interdependence.

Particularity of the Research

⁷⁶⁵ hooks 1995, *supra* note 201, Muñoz, *supra* note 134.

⁷⁶⁶ Singh 2013a, *supra* note 50.

Broad generalizations about trans racialized youth in health care cannot be made on the basis of this research. The results are specific to the experiences of youth who live in the biggest city in Canada in a province where health consent has a presumption of capacity. The focus group data was contextualized, transparent and rich because of the qualitative methods I chose and the research team's success in building rapport and trust with the participants. Qualitative research does not aim to make empirical generalizations from field work, but rather, as in this study, to generate a phenomenology of autonomy in decision making by this group of four youth. These kinds of findings can be useful to other people as the findings can transfer new understandings to other people's lives without universalizing to a whole demographic.⁷⁶⁷ The results offer transferability in part because of the research validation strategies I utilized at all stages of the process.

Conclusion

This chapter illuminated the intimate decision-making experiences of four trans racialized youth through an analysis of their written and visual narratives. Their phenomenology revealed a dismal picture of health care for trans racialized youth in Ontario which contrasts with beliefs held by legislators about the autonomy-enhancing nature of the *HCCA*. They did not feel legal or medical practitioners or social service systems affirmed their autonomy. These findings are consistent with broader relational autonomy scholarship that points to the duty of government to actively support rights as relationships. Participants experienced autonomy as a process not as a

⁷⁶⁷ Chérie Moody et al, "'Without this, I would for sure already be dead': A qualitative inquiry regarding suicide protective factors among trans adults." (2015) 2:3 *Psychol Sex Orientat Gend Divers* 266 at 277; Jonathan A Smith, Michael Larkin & Paul Flowers, *Interpretative phenomenological analysis: theory, method and research* (Los Angeles: SAGE, 2009) at 51.

moment of arrival based on turning 18. At times, their sense of powerlessness over traumatic health care services caused them to avoid health care altogether. And as a result, some did not feel adequately prepared to exercise autonomy when they reached the age of 18. Policy changes are needed at systemic and professional and organization levels to push societal and interpersonal awareness of barriers and how to eliminate them. This research also concludes that greater respect and attention be given to youth's own autonomy-enhancing practices.

Chapter 6: Final Reflections and Recommendations

I begin this conclusion by returning to my research question: How do trans racialized youth experience decision making in health care in Ontario? The short answer is - with great difficulty but showing deep resilience by relying on both agentic strategies and autonomy-enhancing practices. The long answer requires more space to synthesize the results of my thesis and to reflect on its findings. I applied the central insights of relational theory's critique of traditional autonomy to paternalist concerns about health equity law, family law, and the formal gatekeeping role played by health care providers in Ontario. In addition, I brought a multidisciplinary methodological approach to the foreground of pluralist legal inquiry. This meant facilitating Photovoice focus groups, conducting empirical research, and analysing the results through transfeminist and performance theory in order to assess Ontario's intersectional health care environment for decision making.

Specifically, I examined the *Health Care Consent Act*, Regulation 552 of the Health Insurance Act against decisions from the CCB, the SBT, the HSRB and all levels of courts where trans minors and youth were present. I also contrasted the *DSM- V's* psychiatric diagnostic criteria for Gender Dysphoria and the WPATH SoC with non-medical models of transness and community-based primary care protocols from the Sherbourne Health Centre. A practical contribution of this research is its in depth analysis of the relationship between the consent, capacity and substitute decision making provisions of the *HCCA* in intention, on paper, and in application with OHIP coverage criteria for their combined impacts on the health care of trans racialized youth.

I asked corollary questions embedded in legal philosophy guided in part by Spade's pluralist lens of laws as tactics.⁷⁶⁸ How do statutes interact with real life experiences? How do rights work across different areas of law and place where law happens? Are statutory rights effective if affected groups barely know about them? I found that the rights of minors to make their own decisions were ignored in family law custody and access cases. Even when the gender identity of a capable minor child was central to a conflict between parents, and medical testimony and future treatment plans were determinative, judges dismissed the *HCCA* rights of minors to be informed, to consult and to decide. This dismissal undermined the autonomy development of minors. My research illustrated the lingering paternalism of decision makers, especially judges, which manifests in cases involving mature minors and carries over to non-minor youth. Minors and youth are already largely unaware of their rights. This study found that judges tend to consolidate decision-making authority in legal guardians. Legal paternalism is especially dangerous for gender non-conforming minors and youth who might have greater need for medical interventions than cis counterparts and greater likelihood of conflict with guardians over gender identity.

Demonstrating the benefits of interdisciplinary research methods is the third significant contribution this work offers. I stated my affinity for the frameworks of legal pluralism and the transformative paradigm early in my research process.⁷⁶⁹ Therefore, I considered the words and actions of legislators, lawyers, doctors, parents and administrators about health autonomy for minors and youth. I added the key phenomenological ingredient from discussions and photographs produced by trans racialized youth as legal actors themselves. This qualitative

⁷⁶⁸ Spade 2012, *supra* note 199.

⁷⁶⁹ Kleinhans and Macdonald, *supra* note 255 at 31–2.

aspect provided a unique angle on how statutes, case law, interviews and photographs intersect calling forth a richness and heterogeneity of data that is not typical of legal scholarship. Clinical texts and Hansard archives unfolded as subjects, which were intertwined with the first-person narratives of the participants. To further my methodological aim to share my own privileged access to legal information as a researcher, I provided participants with health rights legal information sheets in plain language.

Indebted to the insights of critical race theory - my use of intersectionality extended beyond race and gender because my recruitment methods and analysis included factors of gender identity, disability and body size. Still, systemic and structural racism is extremely hard to prove and to isolate in health care when multiple oppressions are also at play. My findings provide usable evidence of the racism implicit in health care and law with specific references to diverse jurisprudence and several different authoritative clinical and diagnostic texts. I demonstrated what many trans people understand experientially: that the diagnostic criteria for Gender Dysphoria in the *DSM-V* and OHIP's endorsement of the WPATH SoC v7 eligibility criteria have differential impacts on racialized youth due to their structural vulnerability. This work supports the scholarship on trans necropolitics and answers trans of colour scholars' call to acknowledge the besieged material conditions of non- normative trans lives.⁷⁷⁰

I gave current Canadian and Ontario context to the pioneering work of Singh, Gill-Petersen and Kwon in Child and Youth studies by showing the ways that law and medicine combine to create additional barriers for trans racialized youth beyond what white counterparts experience.⁷⁷¹ These barriers continue beyond the traditional age of legal adulthood.

⁷⁷⁰ Haritaworn et al 2014 *supra* note 13, Ware *supra* note 53, and Bhanji *supra* note 49.

⁷⁷¹ Singh 2013a *supra* note 50, Gil-Petersen 2014 *supra* note 54, and Kwon *supra* note 15.

Furthermore, this research suggests that the legal age of majority has now become outdated as a marker for attaining adulthood status especially given the heightened obstacles that trans racialized youth must navigate in terms of health systems, professionals and service provider organizations.

My work confirmed the findings of Pyne, Lee and Dadui in Trans studies, that trans racialized youth perceive themselves and their families as intersectional and distinct from white trans counterparts.⁷⁷² I went beyond studies looking at barriers to health care access for trans youth to theorizing organic responses to coercive pathology from the perspective of agency and autonomy. Pathologizing medical models of transness were determinative in legal decisions such as ODSP appeals made by youth diagnosed with gender dysphoria especially where appeals were successful. I concluded that transphobia and lack of access to gender affirming care due to health care provider incompetence or gatekeeping, and related issues of geographic distance and wait lists were key contributing factors behind appellants' mental health disabilities rather than simply being trans.

I argue that the agentic or protective strategies used by participants in my study confirm findings from other studies about trans (such as Trans PULSE) and structurally vulnerable people's decision making in health generally.⁷⁷³ As Sherwin notes, self-doubt and inability to challenge systems of oppression characterize their agentic strategies.⁷⁷⁴ These short-term strategies were marked by the kind of ambivalence towards power that Butler theorized: performing identities, disidentifying with the gender binary, avoidance of medical care, and

⁷⁷² Pyne 2018, *supra* note 35, Lee, *supra* note 53 and Dadui, *supra* note 124.

⁷⁷³ Scheim et al 2013, *supra* note 74, Scheim 2017, *supra* note 82, Namaste 2000, *supra* note 75, Rotondi, *supra* note 83 and Quesada et al, *supra* note 151.

⁷⁷⁴ Sherwin 1998, *supra* note 157 and Sherwin and McLeod, *supra* note 181.

hiding.⁷⁷⁵ Participants may have performed to meet diagnostic and eligibility criteria but did not conform. My findings also revealed participants carrying out the following autonomy-building practices: self-advocacy, intentional social networks, self-representation, and integrated selfhood.

I engaged with questions central to health equity law: How does the *HCCA* measure up in practice to its aspirations of autonomy for all capable people and streamline substitute decision making? Is health policy responsive to the wishes, bodies, and families of trans racialized youth? In answering these questions, I did not position “autonomy” and “informed consent” as synonyms. And rather than seeing the decision itself as the most important outcome of decision making, I applied Nedelsky’s relational autonomy theory.⁷⁷⁶ I agreed with her conception of rights as relationships that create duties for governments. Policy makers and health care providers cannot magically grant autonomy but can, and should, foster autonomy-producing conditions. I found however, that Nedelsky’s autonomy-producing conditions did not adequately theorize what trans racialized youth experienced. Autonomy is a socially and politically enabled practice. My findings support what Roberts and other feminists of colour have observed which is that justice is a crucial process that fosters autonomy.⁷⁷⁷ Therefore, my list of autonomy-enhancing factors are information sharing, access to justice, transparency of power in relationships, personal responsibility, self-awareness, and interdependence. From this belief in justice and my desire to do justice by the courageous and resilient focus group participants I propose several recommendations.

Based on the combination of my legal research and qualitative methods I have identified the following list of actions and policy interventions. I assert that these actions would greatly

⁷⁷⁵ Butler 1997a *supra* note 212 at 145-147.

⁷⁷⁶ Nedelsky 1989 *supra* note 157.

⁷⁷⁷ Roberts 1997 *supra* note 157.

improve the exercise of autonomy for trans racialized youth in health care decision making in Ontario.

- Change OHIP's policy so as not to require health care providers to strictly apply the Standards of Care v7 in order to approve subsidized treatments.
- Broaden health care coverage for services affecting trans women the most such as electrolysis, voice therapy, and improve the coverage for top surgery.
- Facilitate changing identification documents to match name and gender for those born outside Canada.
- Amend the *Health Care Consent Act* to allow young capable people to exclude specific family members from the automatic substitute decision maker hierarchy (s. 20) and allow for use of a community organization, or chosen family using a Power of Attorney for Personal Care (POA).
- Mandate public legal education and advocacy support for youth about health care rights.
- Do not repeal OHIP+ pharmacare for youth 25 years and younger who are covered by their parents' private health insurance plans.

My research findings in terms of health consent statutes and jurisprudence are Ontario-focused. Some issues however, such as the conflicts between family law and health law are live issues in British Columbia as well and will likely continue to be litigated across Canada until an appellate court sets a precedent. Furthermore, findings related to my focus group are urban and Greater Toronto Area specific and therefore not applicable wholesale to remote or reserve community youth experiences. In addition, I found the ability to consult with lawyers challenging these cases in three different provinces extremely helpful to understand what

arguments were made by counsel and rejected by judges. Therefore, an avenue for further exploration of progressive legal arguments would be through court transcripts in cases involving health rights of trans youth rather than just the final written decisions of judges.

This project marks new directions for community-based research including how to design and deliver public legal education for minors and youth about health rights; more specific work to understand what doctors know and believe, and how to teach health care providers an intersectional approach to fostering the conditions of autonomy is needed. This further research is critical in the face of recent political acts to remove information about gender identity and sexual orientation formerly provided to elementary school minors through health curriculum. Curtailing health information sharing in schools means an even greater reliance on health care providers and other trusted adults to raise awareness that could save the lives of trans racialized youth. This research followed the path of possibilities for nourishing autonomy in decision making over the long term beyond just the assertion of rights.

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Appendices

Appendix A: Pre-Group Questions for Focus Group Participants

1. What kind of role do health care professionals and social services workers play in your life?
2. How do you tell your experiences in order to access health care? Use words and images.
3. How would you describe the relationship between yourself and the communities you feel a part of /take part in?
4. How would you describe and navigate the burden of representation of self as a marginalized person?
5. What health services do you use?
6. What health services do you need but do not have?
7. Which services are transition-related, and which are not?
8. What barriers exist for you in getting the health services you want?
9. What solutions would you propose to policy makers?
10. What solutions would you propose to service providers?
11. How best would you like to receive, review and exhibit the results of the focus groups and research?

Appendix B: Photography Prompts for Participants

The following prompts were used on Day 1 and left with the participants for their image creation week culminating in Day 2:

1. How would you describe the task of representing yourself as a trans bipoc person?
2. How would you describe the relationship between yourself and the communities you feel a part of /take part in?
3. What kind of role do health care professionals (doctors, nurses, therapists) and social services workers (OW, ODSP, CAS) play in your life?
4. How do you tell your experiences and your identity in order to access health care? Use words and images.

Appendix C: Photograph Analysis Rubric

- What do we see/don't see?
- What is shown?
- What do we feel?
- (How) do we relate?
- What does what we see/don't see signify about us?
- How would we use this picture?
- What is the context for the photographer?

Appendix D: Discussion Questions for the Member Checking Session

1. What elements did you emphasize in telling your story to health professionals?
2. What did you hide or change when telling your story to health professionals?
3. Did you manipulate (your understanding of) diagnosis to get what you needed? If so how?
4. Were you allowed to make your own decisions or did someone else make decisions for you? If someone else made decisions, what did you think about the process?
5. Have health practitioners consulted with your parents or other decision makers about your healthcare?
6. When you were under 18 years did this happen and if so how?

Appendix E: Focus Group Agenda

Consent and Coercion in Health Care Decisions 2 Day Art & Discussion Workshop with Trans Racialized Youth April 2017 Flexible Itinerary

Day 1 (6.5 hrs)

- 11:00-11:15 Intros of participants and ice breaking exercises
- 11:15-11:30 Overview of project themes of consent and autonomy in health care decision making (recorded)
- 11:30-12:15 Consent and confidentiality forms distribute supportive resources list with time for discussion of pre-focus group questions (recorded)
- 12:15-1:00 Digital ethics exercise/games; include photo-composition, lighting, editing, consent, privacy (recorded); distribute and explain the consent form for photo subjects.
- 1:00-1:45 Meal and fresh air.
- 1:45-3:30 Sign out cameras using serial numbers; photography exercises in pairs with prompts
- 3:30-3:45 Break
- 3:45-5:30 Health care decision making autonomy discussion (recorded)
- 5:30-6:00 Checkout using photos. Sign out cameras, honoraria and tokens.

Day 2 (6.0 hrs)

- 11:00-12:30 Check-in and review of consent issues and forms; look at art that people created
- 12:30-1:30 Enjoy meal while participants present their art
- 1:30-3:30 We link art to the themes of consent, representation, coercion (recorded)
- 3:30-3:45 Break and snacks
- 3:45-4:30 Discussion of creative solutions to health barriers (recorded)
- 4:30-5:30 Review of next steps such as member checking session

Appendix F: Information for Youth about Consenting to Treatment in Ontario

According to the *Health Care Consent Act*, 1996, c. 2, sched. A, (*HCCA*) there is no fixed age of consent in Ontario when it comes to health treatments. Even children under the age of 12 can make decisions about their health care as long as they can demonstrate the capacity to make an informed decision. Ages of consent are different in each province.

To ensure you make an informed decision, your doctor must tell you the following things in a manner, and using language, you can understand: types of treatment options, benefits, risks, short- and long-term side effects, and consequences of not having the treatment. Your doctor must also tell you about your right to a second medical opinion.

Who determines if a person has the capacity to make a decision? Only a doctor or a health professional can find you incapable of making a decision.⁷⁷⁸ They must tell you if they make this finding. Social workers, teachers and parents cannot determine your capacity to make a treatment decision.

Incapable means the doctor believes, after speaking with you, that you are not able to understand all the information about the treatment and/or you are not able to understand what might happen if you take or don't take the treatment.

A finding of incapacity does not act like a blanket covering all future treatment decisions. If you are found not to have capacity for a particular decision at a particular time, then the doctor will ask a Substitute Decision Maker (SDM) like a parent or caregiver, partner or Children's Aid Society Worker to decide for you. You have the right to choose your SDM from a list of eight categories of people listed in s. 20 of the *HCCA*. Social workers, doctors and foster parents are not on that list, although they can help you to make the decision.

Having a disability or being disabled does not automatically make you incapable. It does not matter if the SDM thinks your wishes are unreasonable or undesirable by their own standards.

⁷⁷⁸ The list of health professionals who can find you incapable is found in the Regulated Health Professionals Act 1991. The rule is that a health doctor can only find you incapable of making a decision about a treatment they themselves can recommend. For example, a dentist cannot find you incapable of deciding to take a puberty blocker drug. That said, if you take a holistic view of your health you may find it useful to speak to different specialists about how the pieces of your healthcare fit together.

The SDM must be led by your values and your perspectives. If you are 16 or over the SDM has the additional rule to follow what your wishes were when you were capable, by checking what you wrote down or said to the SDM or other people.

If you want to challenge your doctor's finding of incapacity you can apply to the Consent and Capacity Board (CCB). The CCB can also change your SDM to a person of your choice, if that person agrees to that role and both of you are at least 16 years old. You will need to contact the CCB. Once you tell them why you are contacting them they will provide you with forms to fill out and sign in order to start your application. It is a very good idea to speak to a legal clinic or a lawyer about applications to the CCB.

Creating a document called a Power of Attorney for Personal Care (POAPC) is another option for supported health care decision making. It does not require a court process. You must be at least 16 years old to appoint an attorney for personal care and do it while you are capable. The attorney that you give power to does not have to be a lawyer, and they should be someone you trust who knows your values and beliefs. The POAPC document requires your signature and signatures of two witnesses. If you are found incapable for a particular decision, the person you choose as your attorney for personal care would automatically become your SDM, trumping relatives and CAS workers. When you are capable again, the attorney does not make decisions for you.

Speaking to a lawyer about the role of an attorney for personal care is highly recommended because their duties are quite a bit broader than those of an SDM and includes other areas of your life such as housing.

If you want to cancel the POAPC, you can revoke it by writing down that you revoke the POAPC and have two witnesses sign that they watched you sign the revocation. All of you should include the date that you are signing. Keep the original POAPC and the revocation documents together in a safe place.

Useful Resources

College of Physicians and Surgeons of Ontario

Phone: Public Advisory Department at 416-967-2603 or 1-800-268-7096, extension 603

Website: <http://www.cpsso.on.ca>

Contact them if

- you have questions or concerns about how your doctor communicated with you, the information they kept or shared with others, the treatment you received, or how your consent was given or not given for treatment

Consent and Capacity Board

Phone: 416-327-4142 or 1-866-777-7391 (toll-free in Ontario)

Website: <http://www.ccboard.on.ca>

Contact them if

- your doctor has said you are not able to make a treatment decision and you disagree
- you are at least 16 years old and want to change your Substitute Decision Maker

Justice for Children and Youth

Phone: 416-920-1633 or 1-866-999-5329 (toll-free)

Blog: <http://jfcy1.blogspot.ca/>

Website: <http://www.jfcy.org>

Contact them if

- you want information or legal advice
- you are looking for a lawyer to represent you in court or at a Board hearing

Office of the Provincial Advocate for Children and Youth

Phone: 416-325-5669 or 1-800-263-2841 (toll-free)


Website: <http://www.provincialadvocate.on.ca>

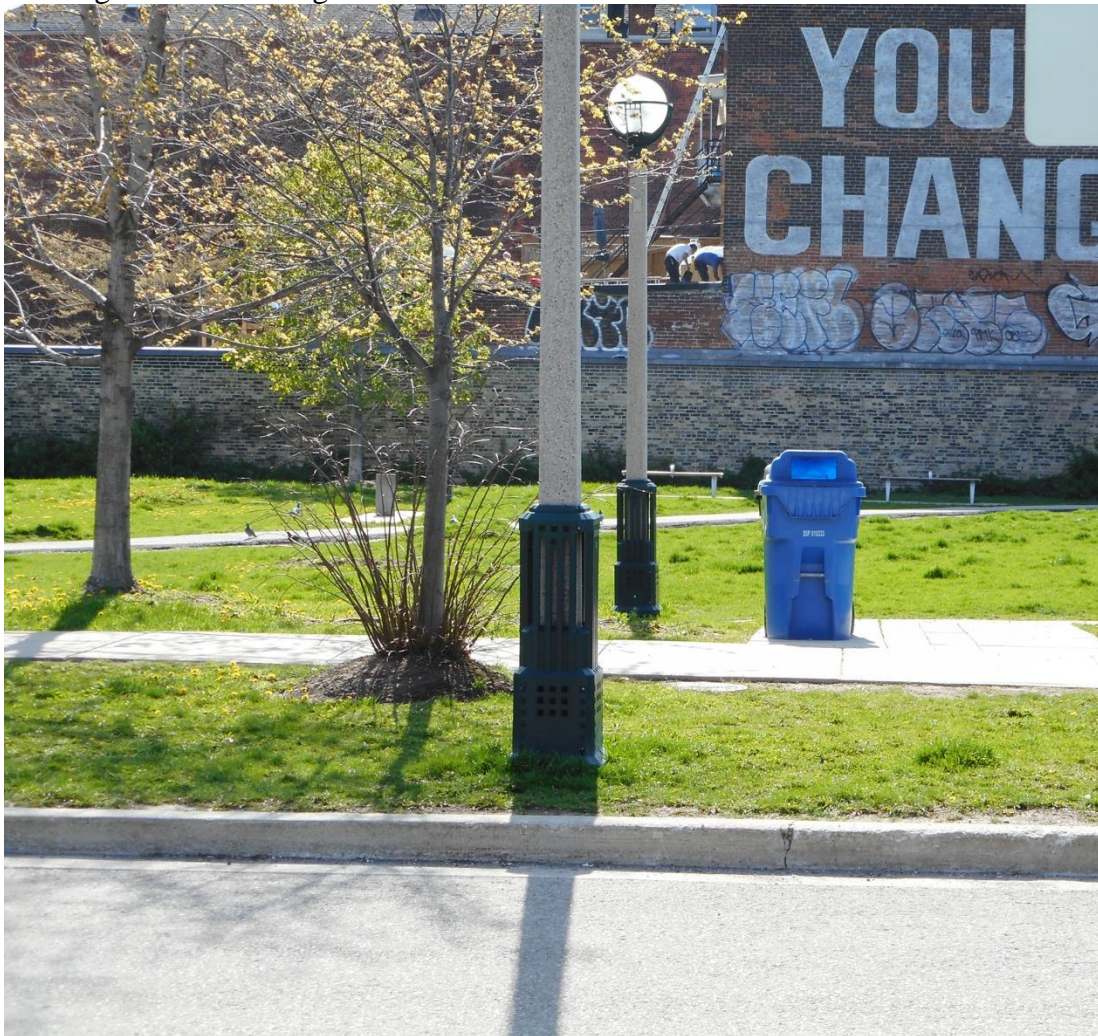
Contact them if


- you have questions about health care rights
- you feel that someone is violating your health rights


Table of Photographs

Table 1. List of Photographs (see p.viii)

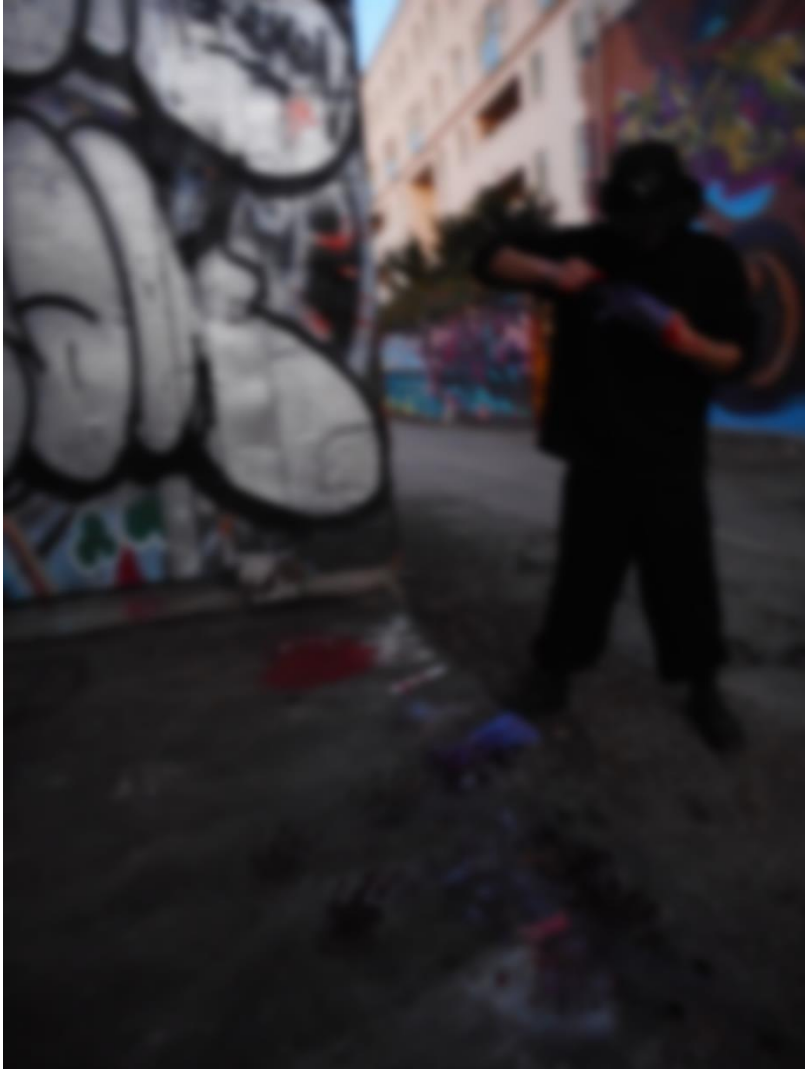
Creator	Full Title
Pogi	<p data-bbox="337 346 1068 415">Think Before You Scream (Photo has been pixelated to protect identifiable features)</p>  A pixelated black and white photograph of a person, likely a man, wearing a white shirt. A bright blue circular object, possibly a microphone or a badge, is visible on the person's chest. The image is heavily pixelated, making details difficult to discern. The background is dark and indistinct.

Creator	Full Title
Pogi	<p>Reading Between the Signs</p> 


Creator	Full Title
Pogi	<p data-bbox="337 304 1015 373">Alone Together (Identifiable features in the photo have been blurred)</p> 


Creator	Full Title
Pogi	Dick Pick 


Creator	Full Title
Sakura River	<p data-bbox="337 306 1036 373">UHN Invoice (Photo has been pixelated to hide identifiable features)</p> 


Creator	Full Title
Sakura River	<p data-bbox="337 304 1011 373">Bloody Glove Series 1 (Photo has been blurred to hide identifiable features)</p> 

Creator	Full Title
	<div data-bbox="581 296 1182 1098" data-label="Image"> A photograph showing a person from behind, wearing a dark, hooded jacket and dark pants. They are standing in a room with walls covered in graffiti. The floor is dark and has several colorful paint splatters, including red, blue, and purple. The lighting is somewhat dim, and the overall atmosphere is gritty and urban. </div> <p data-bbox="337 1098 1036 1171">Sakura River - Bloody Gloves Series 2 (Photo has been modified to hide identifiable features)</p>


Creator	Full Title
	 <p data-bbox="337 1367 824 1402">Sakura River - Bloody Glove Series 3</p>


Creator	Full Title
Sakura River	<p>Flags (Photo partially blurred to hide identifiable features)</p> 


Creator	Full Title
Sakura River	<p data-bbox="337 306 557 338">Light After Dark</p>  <p data-bbox="337 373 1430 1434">A photograph taken from an elevated position looking down at a city at night. A vibrant rainbow arches across the sky, its colors appearing somewhat muted due to the distance and atmospheric conditions. The city below is illuminated by various lights, including streetlights and building lights, creating a bokeh effect. In the foreground, there are dark silhouettes of trees and a white structure, possibly a fence or part of a building. The overall mood is serene and magical, capturing a rare natural phenomenon in an urban setting.</p>

Creator	Full Title
Participant #4	<p>The Ground is a long way down but there is more than one way to be grounded</p> 

Creator	Full Title
Participant #4	<p>Discarded, Forgotten and Hidden. Sometimes Compartmentalized</p> 

Creator	Full Title
Participant #4	<p>Community, Family, chosen or otherwise taking on the world together</p> 

Creator	Full Title
Participant #4	<p>I never Said I was Ugly, It doesn't make me Sick</p> 

Creator	Full Title
Participant #4	<p>Who goes out? Who gets to be seen? Who am I to you?</p> 

Creator	Full Title
Participant #4	<p>We Spend Some Time Together and Avoid the Medical Gaze (Photo has been blurred to hide identifiable features)</p> 